Arkansas Statewide MEDICARE / MEDICAID Locality Evaluation Study

Volume I

Analysis of Year One Data

1978-1979

1982

DIVISION OF OPERATIONS
OFFICE OF PROGRAM ADMINISTRATION
BUREAU OF PROGRAM OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION

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I

INTRODUCTION

As a result of a request from the Arkansas Medical Society, the Health Care Financing Administration (HCFA) permitted the Medicare carrier, Arkansas Blue Shield, to convert from the then existing five-locality system to a statewide basic fee structure for reimbursing physicians. An evaluation of selected impacts of that change in the first year following its implementation is presented below.

The methodology which has been developed for evaluation of the Arkansas change has also been developed and documented so that it may be applied, with appropriate modifications, to other similar situations contemplating a change in locality structure.

Under Part B of the Medicare regulations, physicians are reimbursed on the basis of "reasonable charge" determinations, which are calculated for each designated physician specialty class and procedure based on:

- The physician's customary charge for that service
- The prevailing charge for similar services in the locality
- The actual charge billed by the physician.

The reasonable charge paid is based on the lowest of these three charges, the first two of which are calculated annually. The change from a multi-locality to statewide fee structure affects the second of the three above-listed charges.

The five-locality system has existed in Arkansas since 1966, when the Medicare program began in that State. It was based on the existing knowledge of geographically-based charging patterns in Arkansas at that time. Localities under the Medicare program form the geographic basis for determining the "prevailing" charge portion of the reasonable charge calculation. Multi-locality based prevailing charges are applied to a particular subset of providers and services reimbursed under Part B of the Medicare program. In March 1978, the new statewide locality system was implemented in Arkansas for the Medicare program.

An additional ramification of the conversion is that the Arkansas Medicaid program, which also uses Medicare fee screens for part of its fee determinations, was affected by the changeover.

It was anticipated that the modification in the procedure for calculating reasonable charge would result in a number of operational and financial effects which could include:

- Readjustment of physician fees due to the single statewide system
- Relocation of some physicians to more rural areas as incentive to practice in the higher cost urban areas decreases
- Changes in both Medicare and Medicaid program payments
- Changes in the availability of medical services in certain areas
- Adjustments in Medicare beneficiary liabilities for meeting co-insurance provisions of the program
- Changes in payouts on Medicare/Medicaid eligible claims

The purpose of this evaluation is to assess the impact of the change in reasonable charge calculations over the period July 1978 through June 1980, the first two fee screen years following implementation of the change. The methodology for measuring the impacts of the change on both programs includes simulation of the normal process for determining reasonable charge for selected services under two conditions: 1) the statewide locality structure, and 2) the five-locality structure. An analysis of appropriate existing statistical reports on medical manpower in Arkansas has also been undertaken.

Volume I presents the findings on the impact of the change from a multi-locality to a statewide basis for calculating reasonable charge based on data for the period July 1978 through June 1979--the first fee screen year (FSY 1979) following implementation of the change.

For Medicare total payouts, the most urban locality, Locality 1, shapes the direction of the findings as a result of the preponderance of medical services billed in that locality. Thus the simulation indicates that under the statewide system total program payouts for the Medicare system are slightly, but insignificantly reduced. Beneficiary liabilities for assigned cases are likewise reduced and liability for unassigned cases increased substantially (2.3 percent). The total increase in beneficiary liability, however, is only about 1 percent.

Medicaid payouts utilizing the statewide methodology are reduced by about 3 percent--a significant reduction from the multilocality payout simulation.

Payouts by Medicare and Medicaid crossover claims show a substantial reduction under the statewide methodology--about 4 percent.

For the special procedures, Office Follow-up Visit and Hospital Follow-up Visit, there was no significant difference in total payouts for crossover claims, Medicare assigned claims, and Medicaid payouts between the two simulation methods. There is, however, a significant increase in the unassigned beneficiary liability for both procedure codes utilizing the statewide methodology.

For type of charge selected as reasonable charge, comparing submitted, customary and prevailing charges for both Medicare and Medicaid programs, there is a large difference between proportion of prevailing charges selected under the two simulation methods in Locality 1, the most urban locality, with the prevailing charge selected more frequently under the statewide simulation. The Medicare and Medicaid programs differ in that the customary charge is much more likely to be chosen as reasonable charge under the Medicaid program than the Medicare program.

Assignment rates were slightly above 50 percent for the year, with the rural localities showing a somewhat higher assignment rate than the urban localities.

Health manpower statistics for Arkansas and data on physician movement indicate very little movement by physicians, but a general increase in the number of physicians for total population. No support was given to the argument that a change in the locality system will encourage physicians to locate or relocate in rural areas.

In sum, very little adverse impact on medical services in Arkansas as a result of the change in the locality system can be demonstrated; however, there is no indication substantive positive impacts from the locality change either.

II

BACKGROUND

Both Medicare and Medicaid programs in Arkansas are to be included in this evaluation. The two programs differ in several respects. First, Medicare is a federally-operated and wholly federally-funded program providing medical care primarily to the aged (those over 65). Medicaid, on the other hand, is a state-operated program which is subsidized by the Federal Government. It provides medical services primarily to welfare recipients, but also to certain persons whose incomes are sufficiently low so that heavy medical costs would cause them to become impoverished. Claims are reimbursed by Arkansas Blue Cross/Blue Shield for both programs.

The two programs are linked together legislatively and in practice. Legislatively, because the Federal Government provides funding to both programs and therefore places certain restrictions on the Medicaid as well as Medicare programs. In terms of this study, the prohibition against Medicaid payments exceeding Medicare payments to a particular doctor for a comparable service means that the Medicaid determination of its reasonable charge for a claim will be impacted by the change in Medicare's locality structure.[1] Also, where the populations served by the two programs overlap and claims are paid by both programs, a cooperative process for reimbursing physicians exists between them.

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[1] This prohibition was in effect during the period being studied but was repealed by the Omnibus Reconciliation Act of 1981.

A. Definitions of Key Terms

Central to the understanding of this study is the concept of reasonable charge. The methodology for determining reasonable charge to physicians and other suppliers of medical services and materials included under Part B of the Medicare program was established by Congress. A reasonable charge is based on a comparison of three charges:

1. The charge submitted by a physician or supplier for a covered service.

2. The "customary" charge, applicable to a particular physician and service.

3. The "prevailing" charge, applicable to a particular physician group, a particular locality, and a particular service.

The lowest of these three is selected as the reasonable charge for a service; and, normally, 80 percent of that charge (less any outstanding deductibles) is paid by Medicare for the claim. For Medicaid claims, 100 percent of the determined reasonable charge is paid.

The following terms and concepts are vital to this study. They are presented here to introduce the analysis of impacts of the change in the physician reimbursement system and to facilitate reference to them by the reader as the discussion and analysis proceed.

Customary charge. "The amount computed by the carrier based on actual charge data for a specific service performed by one physician (or other supplier) to the physician's patients in general."[2] The customary charge is the charge which is high enough to include the median charge for that service by that physician and is based on the claims for services performed in the calendar year prior to the fee screen year in which it is applied (e.g., the claims for services for 1977 calendar year are used to establish the customary charge for FSY 1979).

Prevailing charge. "The lowest charge of the array of customary charges which is high enough to include 75 percent of all the customary charges."[3] The prevailing charge is based on the customary charge for all physicians within a particular specialty group and locality, (weighted by the number of services represented by each customary charge for the Medicare program).

Submitted charge. The actual amount billed by a physician or service/equipment provider which may include one or more services. This is the same as the term "claim" used elsewhere in this report.

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[2] Determination of Reasonable Charges Under Part B of Medicare: A Training Workbook, HCFA, Baltimore, Maryland, p. 46.

[3] Ibid., p. 47.

Carrier. "A commercial insurance firm or Blue Shield administering Part B of Medicare. It is distinguished from commercial insurance plans or Blue Cross plans administering Part A which are referred to as intermediaries."[4]

Locality. A locality is usually a political or economic subdivision of a state which is delineated by a carrier for the purpose of deriving prevailing charges for services. It should include a cross-section of the population on economic and other characteristics. Localities were provided for in Medicare regulations to take advantage of existing knowledge of charging patterns within a state. They were developed on private claims experience by carriers before the Medicare program was implemented.

Specialty. A group of physicians working primarily in a certain area of medicine. These categories provide part of the criteria for establishing prevailing charges, since it is assumed that a "specialist" in a particular functional area of medicine could be expected to have a different charging pattern for a service than, for instance, a general practitioner providing the same service. For example, it is reasonable to expect that a dermatologist removing a wart would charge a different fee for the service than a general practitioner providing the same service, based on specialized training and experience in the case of the former.

Procedure. A "medical service" provided by a physician, designated for the purposes of this study by either of two coding methods for medical services--the California Relative Value Scale (CRVS) of 1964 utilized on Medicare claims and the Physicians' Current Procedural Terminology (CPT), editions 3 and 4, utilized by the Arkansas Medicaid program for submitted claims.

Fee screen year. A one-year period from July 1 through June 30 of the succeeding year. Claims received during this period are "priced" utilizing claims for services rendered in the preceding calendar year. Hence, claims received during FSY 1979 (July 1, 1978 through June 30, 1979) are priced using fee screens developed on calendar year 1977 claims for services.

Fee screens. The total matrix of charge limitations calculated by the carrier. They are compared with the charges submitted during the fee screen year in order to determine reasonable charge for a claim.

To reiterate then, the reasonable charge is based on selection of the lowest of three charges, two of them derived from the prior calendar year's claims. This is the basic process which was simulated in the current study for FSY 1979 (July 1, 1978 through June 30, 1979), and FSY 1980 (July 1, 1979 through June 30, 1980).

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[4] Ibid., p. 45.

Assignment. Under Medicare, assignment means that the physician agrees to accept as total payment for a service the reasonable charge calculated by Medicare. If the claim is "unassigned" the physician does not agree to accept the reasonable charge as his total payment. If a claim is "unassigned," Medicare pays 80 percent of the calculated reasonable above the deductible and the patient is responsible for the balance of the difference between the amount remitted by Medicare and the submitted charge. If a claim is "assigned," the patient is liable for the 20 percent of the calculated reasonable charge not paid by Medicare. Assignment is established on a claim-by-claim basis, and may vary during the course of treatment of a single patient for a single complaint. Under Medicaid, all cases are "assigned," i.e., the physician must agree to accept the Medicaid-determined reasonable charge as total payment.

Beneficiary liability. For Medicare assigned claims, the patient is responsible for 20 percent of the reasonable charge. For unassigned claims, the beneficiary (patient) is responsible for 20 percent of the reasonable charge plus any amount above the reasonable charge billed by the provider/physician.

Pricing. Determining the payout for claims; i.e., determining reasonable charge for a claim and amount to be paid by either Medicare or Medicaid (e.g., for Medicaid, usually 100 percent of the reasonable charge and for Medicare, 80 percent).

Crossover claims. Where a patient is eligible under both Medicare and Medicaid programs, Medicare determines the reasonable charge and pays 80 percent of the payment; and in Arkansas Medicaid has opted to remit the remaining 20 percent (of the Medicare calculated reasonable charge) to the physician.

Multispecialty clinics. Customary charges are developed for clinic service by a physician, and if there is a private practice for the same physician, a second customary charge is calculated. Customary charges are calculated separately for each multispecialty clinic from which the physician submits claims to Medicare. (Medicaid does not consider clinic practice separately in Arkansas and calculates only one customary for each physician.)

Unispecialty clinics. Under Medicare, these clinics are treated as if they were a physician, so that a customary charge is developed on all charges for a service submitted from the clinic, regardless of the physician performing the service.

Economic Index. This limitation is calculated from a formula which reflects increases in costs of providing medical services, based on the costs of office practice and earnings levels in the population as a whole.

Weighted average reasonable charge. A summary measure of average payment for services within a category, derived by taking total payout for a category and dividing by the number of services which were reimbursed by the payout amount.

B. Steps Toward Completing the Evaluation

In order to meet the requirements of the evaluation and, at the same time, work within the limitations of the data which could reasonably be obtained for this project, the following steps have been taken toward completing the evaluation and producing a transportable methodology:

- Procedures for reimbursing physicians for both Medicare and Medicaid programs have been studied for periods prior to and during the two-year study time beginning July 1, 1978 and ending June 30, 1980.
- Descriptions of claims processing computer operations for Medicare and Medicaid have been obtained and tapes containing data for calculating fee screens and for pricing claims for the study period have been requested.
- The Profile Development System (PDS) methodology utilized by Arkansas Medicare and Medicaid programs and the CPT and CRVS coding schemes utilized for determining fee screens have been studied.
- A procedure mix has been developed which reflects the majority of services performed within the three physician payment groups (Medical Specialties, General Practice, and Surgical Specialties) and which represents a large proportion of Medicare and Medicaid program payouts.
- An approved methodology for producing tabular, graphical and explanatory results has been developed which both measures and correlates the changes in locality structure with the following:

    1. Medicare Program Payments
    2. Medicaid Program Payments
    3. Medicare-Medicaid Program Payment Interface
    4. Availability of Medical Services
    5. Program Payout for the Unique CRVS Procedure Codes for Office Follow-up Visit and Hospital Follow-up Visit
    6. Locality and Statewide Prevailing Charges and Corresponding Weighted Average Reasonable Charges for Selected Procedures
    7. Estimated Totals for Medicare Program Payouts
    8. Assignment Rate Changes in Medicare
    9. Potential Beneficiary Liability
    10. Medicare Program Claims where Reasonable Charge Equals Prevailing Charge
    11. Medicaid Program Claims where Reasonable Charge Equals Prevailing Charge
    12. Medicare-Medicaid Claims where Reasonable Charge Equals Prevailing Charge

- Visits were made to South Carolina and Arkansas Blue Cross Plans.
- Specifications for data requirements, which are computer independent of the organizations providing data, and at the same time specific enough to be used by the contractor and State agency providing the data, have been prepared and submitted to the Arkansas carrier.
- Programs to reduce the volume of the computerized databases have been developed.
- Programs have been developed to produce fee screens for both the five-locality and one-locality analyses, including programs to price claims under each locality structure and to produce tables of comparative data.

III

THE ARKANSAS SITE

In March 1978, a revised methodology for calculating 'prevailing charges was implemented by Arkansas Blue Shield, the carrier for Part B of the Medicare program in the State of Arkansas. This new procedure--a conversion from the five-locality to a statewide system--responded to a request from the Arkansas Medical Society to the Medicare Bureau for such a change.

The society argued that the then current system discouraged physicians from locating in rural areas, since the prevailing fees for rural localities were substantially lower than those for the same services in urban areas. The Medicare Bureau evaluated the customary charging patterns for physicians in the State of Arkansas, using the Service Area Wide (SAW) methodology developed for this purpose, and found that the five-locality system did, in fact, reflect true differences in charging patterns throughout the State, and thus complied with the intent of regulations governing locality designations for the Medicare program.

However, the Medicare Bureau granted the change to a statewide system on an experimental basis and contracted for a study to evaluate the impact of the change on selected aspects of the State's medical environment. A dual purpose was envisioned for the study: 1) to evaluate the specific impacts on medical services in the State of Arkansas; 2) to provide a general methodology which could be applied, with modifications, to other sites entertaining the idea of changing to a statewide system.

A. Medicare and Medicaid in Arkansas

The carrier for both Medicare and Medicaid in Arkansas is Blue Cross/Blue Shield (ABCBS). ABCBS has administered the Medicare program since its inception in Arkansas in 1966. However, Medicaid claims were processed separately from the Medicare program until July 1, 1978, when the Arkansas Department of Human Services, Division of Social Services, which administers the Medicaid program for Arkansas, contracted with ABCBS to act as its intermediary for the Medicaid program as well.

B. The Arkansas Locality System

In general, a locality is identified as a politically or economically delineated geographic area which includes a cross-section of the population in terms of economic and other characteristics. In Arkansas the five localities were based on economic considerations,[1] i.e., actual differences in charging patterns by physicians in the different areas. (See Appendix III for a list of counties included in the respective localities.) The Arkansas localities, therefore, were in accord with Medicare regulations which state:

> "For the purpose of making reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for services. Usually a locality will be a political or economic subdivision of a State, and it should include a cross-section of the population with respect to economic and other characteristics." (5020.1 Determination of Locality. Medicare Carriers Manual, January 1977.)

The localities as they existed in 1977 have been described on an urban to rural continuum as follows[2]:

Locality 1: 2 counties, urban, approximately 771 physicians, 83 percent specialists

Locality 2: 6 counties, urban, approximately 382 physicians, 76 percent specialists

Locality 3: 6 counties, suburban, approximately 143 physicians, 42 percent specialists

Locality 4: 15 counties, suburban-rural, approximately 263 physicians, 37 percent specialists

Locality 5: 45 counties, rural, approximately 258 physicians, 8 percent specialists

Figures 1 and 2 show the counties of Arkansas, present relevant data regarding the supply of physicians in them, and identify the five-locality system.

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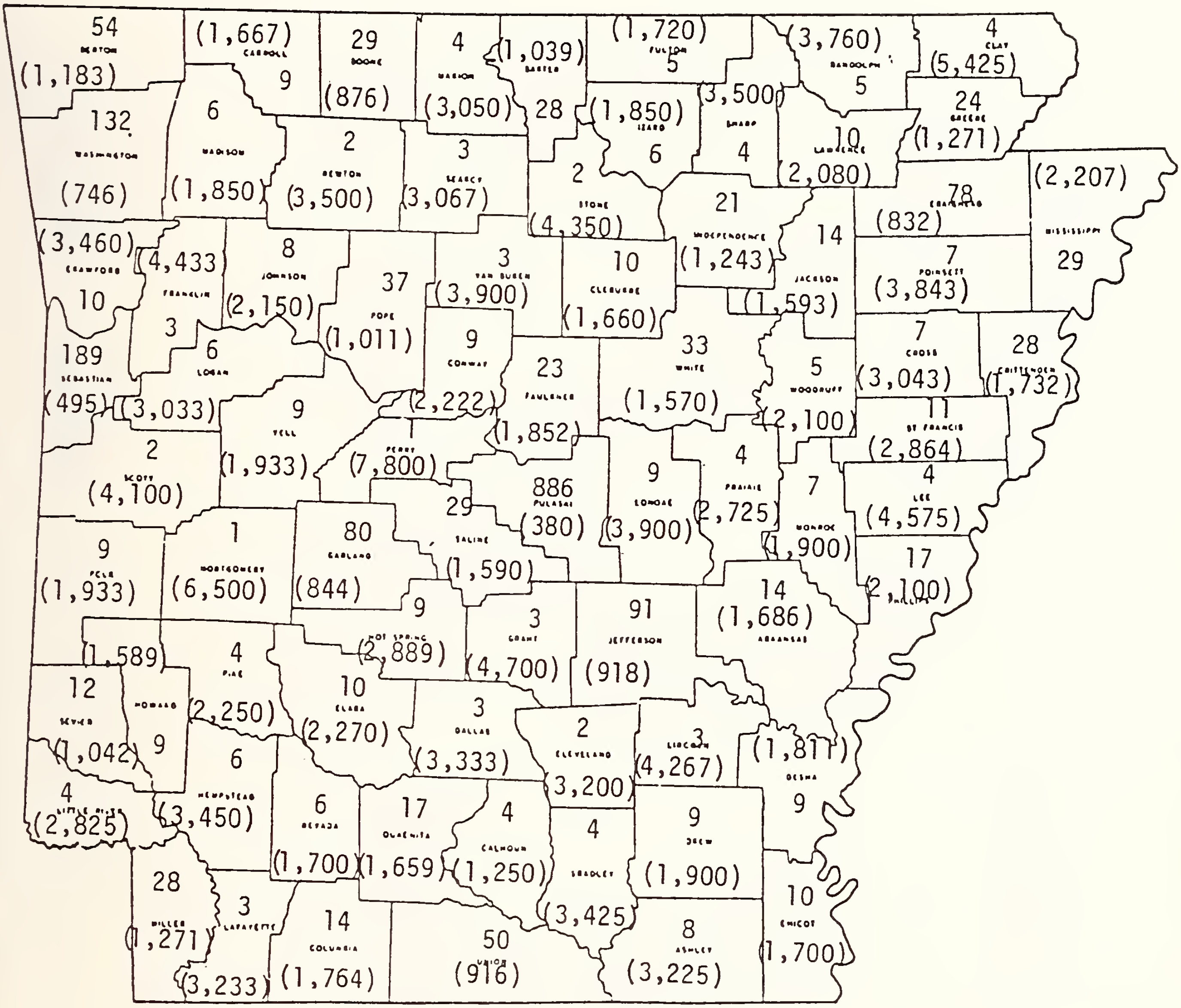
[1] Regional Carrier Letter No. 77-8, Reasonable Charge Survey, XIII.C.1. "Localities were set up based on economic conditions within each county established by the Medical Society."

[2] See Memo from Jim Reed, DHEW, HCFA Dallas Regional Office, February 1, 1978 to James R. Merryman. Also, see accompanying maps.

Figure 1

Active Physicians and Population/Physician Ratio

Arkansas: 1979



By County: Number of active physicians and population/physician ratio ( ), 1979 figures.*

*Arkansas Health Manpower Statistics, Physicians, 1979, Division of Health Statistics, Arkansas Dept. of Health.

Figure 2

The Arkansas Five-Locality System
1978

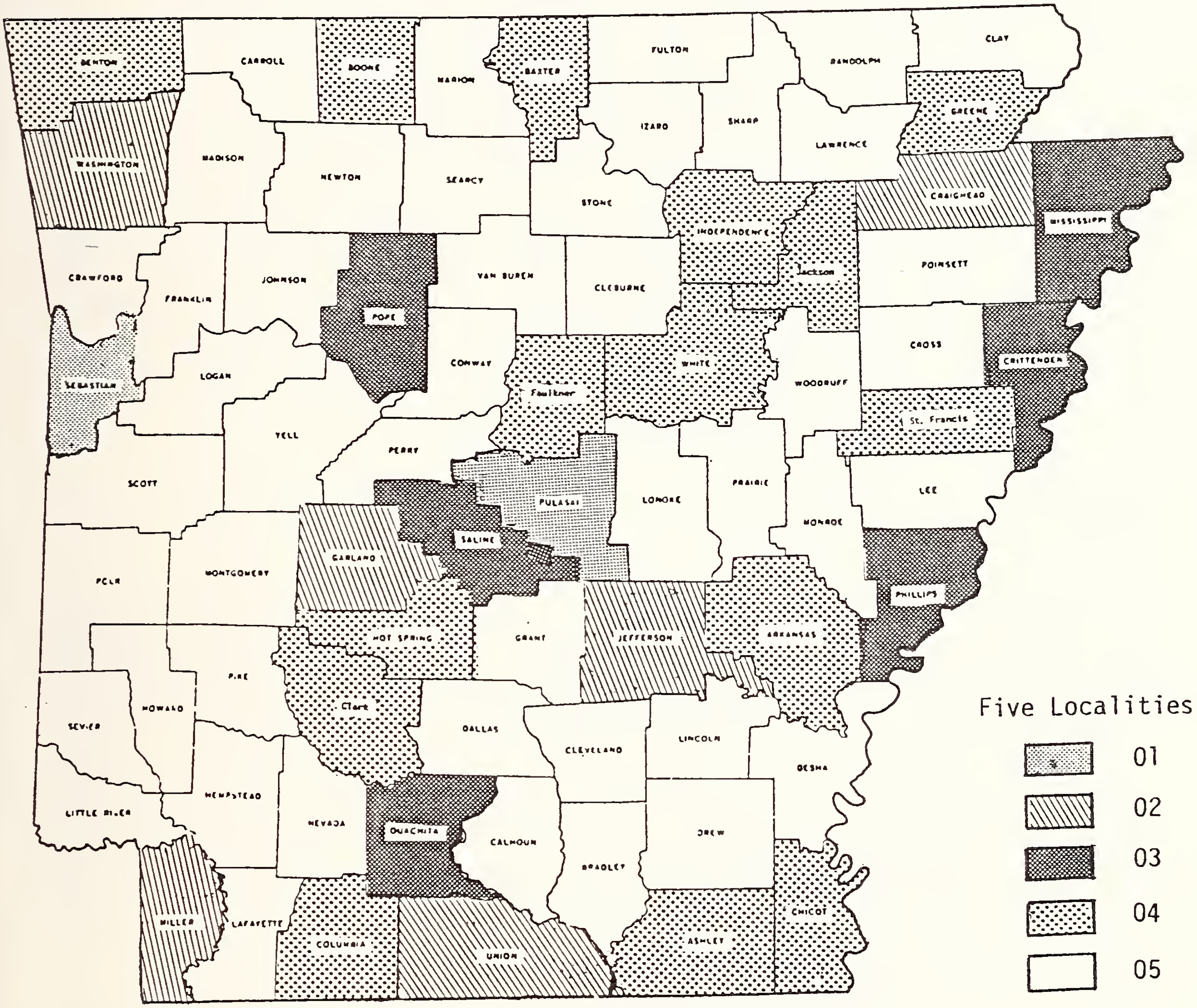


Figure 1 presents numbers of active physicians within each county in Arkansas during 1979 and the population-to-physician ratios for each county. Figure 2 shows the Arkansas locality system as it existed immediately prior to the conversion to a statewide system. The high population-to-physician ratios in the more rural areas can be compared to the lower ratios in the more urban areas. The concentration of active physicians, particularly in Pulaski County, (Locality 1), can also be observed.

It should be recalled that one of the purposes of this evaluation is the determination of whether changes in the basis for calculating prevailing charges will encourage physicians to relocate or locate within rural areas. More will be said about this in Chapter V.

Currently, Arkansas is one of 17 jurisdictions (i.e., of the 50 States and the District of Columbia) with a statewide system for calculating prevailing fees. There seems to be a gradual trend in the direction of simplifying the calculation of prevailing charges to a statewide system, with two more states now exploring the possibility of going to a one-locality system. In 1977, there were only 13 jurisdictions with a single locality. Thus, Arkansas is not an isolated case but can be viewed, rather, as part of a National trend.

C. The Computer Software

Prior to November 1, 1979, Medicare claims were processed for Arkansas Blue Shield by Optimum Systems, Inc. Claims are now processed in-house, utilizing the system developed by Optimum Systems specifically for processing the Arkansas Medicare claims. Optimum Systems has not maintained the Medicare database since the end of 1979 when ABCBS took over its own processing.

Medicaid computer software for claims processing, on the other hand, is a general package for the purpose of health claims processing (MMIS) purchased by Medicaid and maintained by Blue Cross of Arkansas. Medicaid payments for physicians' services were administered by the Arkansas Department of Social Services until July 1978, when claims processing was turned over to Arkansas Blue Cross/Blue Shield.

Prior to October 1978, Medicaid utilized fee screens (customary and prevailing charges) developed by ABCBS for Medicare claims processing (i.e., determining reasonable charges). Beginning with 1977 calendar year data, Medicaid has developed its own customary charges, which are then compared with Medicare customary charges. It continued to utilize Medicare prevailing charge screens. Customary charges developed by Medicare were used until October of 1978, when the customaries based on 1977 Medicaid claims data were implemented. Prevailing charges and customary charges developed on 1978 calendar year Medicaid claims were implemented (after appropriate comparison with Medicare screens) in January 1980 and have been in use since then.

There is, therefore, a very close relationship between the Medicare and Medicaid systems insofar as determination of reasonable charge is concerned. Naturally, the change in the Medicare locality system impacts the Arkansas Medicaid program in a manner analogous to the Medicare program.

Medicare fee screens are updated regularly, using claims for services performed in the preceding calendar year to develop the customary and prevailing charges. The new screens are implemented for pricing claims received on or after July 1 of the following year.

The very different claims processing software utilized by the two programs and the different schedules for updating fee screens have required significant modifications to the evaluation methodology to reflect the unique characteristics of each program.

D. Coding Systems for Medical Procedures

A major difference in the two systems is the use of the California Relative Value Scale (CRVS) coding system by Medicare to identify medical procedures for claims processing and the use of the Physicians' Current Procedural Terminology (CPT) coding system by Medicaid for its claims processing. A cross-referencing system is required by law, since Medicaid must compare its fee screens to those generated by Medicare for the same procedures and for the same physicians. Medicaid cross-references between the CRVS system utilized by Arkansas Medicare and its own CPT system and then uses the CRVS system to compute its fee screens. Nonetheless, the cross-referencing is not precise and is in some cases rather arbitrary.[3] Because the Medicaid coding system recognizes the larger number of categories provided by the CPT system, several Medicaid procedures may be included in a single Medicare code. This situation is further complicated by the change from CPT-3 I to CPT-4 by Medicaid during the study period (i.e., July 1, 1979).

Given the above-described conditions existing in Arkansas, a methodology was developed which permits the evaluation of the change from a multilocality to a one-locality system and, at the same time, is compatible with the characteristics of the Arkansas setting. A detailed description of the methodology follows.

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[3] See Cross-Reference Memorandum and Accompanying Reports, Arthur Anderson & Company, November 1979, on this subject as it applies to Arkansas.

IV

EVALUATION METHODOLOGY

The evaluation methodology consists principally of a system for simulating both the statewide and five-locality processes for calculating prevailing charges and for "pricing" (i.e., calculating reasonable charges) claims submitted by physicians to Arkansas Blue Cross/Blue Shield under the Medicare and Medicaid programs. The system is not a duplicate of the Arkansas process, but rather implements a procedure consistent with Federal regulations governing the calculation of Medicare fee screens. This ensures the methodology will be generally applicable to other sites anticipating a change from a multi- to single-locality system. Only services priced by normal procedures are included in the analysis, since only such claims will be impacted by the change in normal pricing process. With this approach, many possibly confounding factors are "held constant" in order to analyze the impact of the change alone.

Although the research has been specific to the Arkansas site, an eye toward applications to other States has also shaped the methodology developed for the Arkansas evaluation project. Therefore, the most generally applicable characteristics of the fee screen development system utilized by the Medicare and Medicaid programs in Arkansas have been identified and included in the system, while unique characteristics have been deemphasized, so that needs for an evaluation of impacts at other sites would not be jeopardized.

In order to get a broader overview of the comparability of the Arkansas system to other State systems, studies of a similar nature on changes from multi- to one-locality systems in South Carolina and Colorado were examined. Visits were made to Arkansas and South Carolina for on-site data gathering. Site visit reports have been submitted to HCFA.

A The Simulation

Tapes containing data on physicians' paid claims have been received from Arkansas Medicare and Medicaid programs. The files include all paid claims for both programs which are appropriate to the purposes of the evaluation, i.e., physician claims normally priced by the comparison of customary, prevailing, and submitted charges to select the lowest as reasonable charge. Paid claims from January 1, 1977 to July 1, 1980 have been supplied. The 1977 claims are included in order to permit calculation of fee screens for FSY 1979 (July 1, 1978 through June 30, 1979).

Data needed for the study are extracted from the raw data files and are formatted and coded in order to reduce costs and facilitate the analysis. Two sets of fee screens are developed--one simulating the five-locality system and the second the statewide system. Claims are priced under both methods, and

results are compared to determine the effects on program payouts, beneficiary liability, assignment rates, Medicare-Medicaid interface, proportions of submitted, customary, and prevailing charges selected as reasonable charge for claims, and on two procedure categories: Hospital Follow-up Visit and Office Follow-up Visit.

B. *Criteria for Selecting Procedures*

Following HCFA contract specifications, a procedure mix has been identified which reflects the majority of services performed within the three physician payment groups: Medical Specialties, General Practice, and Surgical Specialties. (See Appendix I.) This mix simultaneously represents a large proportion of Medicare and Medicaid program payouts.

The criteria used to select the appropriate procedure codes are (with some exceptions described more fully in Appendix II): 1) That a procedure occur at least 600 times in one of two ABCBS-supplied source listings on frequency of claims (one for Medicare and one for Medicaid) for a particular procedure; 2) That the annual dollar value of payout for a procedure code equal or exceed $30,000; and 3) That the procedure is priced by the normal means for determining reasonable charge. An extensive analysis of the two Arkansas procedure coding systems--i.e., the CRVS system utilized by Medicare and the CPT system utilized by Medicaid--was necessary to create a list which met the requirements of the evaluation.

C. *Customary Charge Calculation*

Medicare and Medicaid follow slightly different procedures for calculating customary charges, which are reflected in the study methodology. For Medicare, the number of services included in a particular bill submitted by a physician is taken into account in calculating the customary charge. Thus, the customary charge calculated for Medicare is based on the unit charge and the median (50th percentile) is determined by the service frequency associated with the ranked unit charges. If a physician submits a bill for $75 representing three services, the amount ranked for calculating the physician's customary under the Medicare program is $25. Services associated with each unit charge are summed until 50 percent of all services performed by that physician within that "procedure" category have been accounted for. The associated ranked unit charge, or the next higher charge, is the physician's customary charge. A minimum of three submitted charges is required to establish a customary.

For the Medicaid program, only one charge is required to establish a customary. Submitted charges are ranked regardless of the number of services, and the median submitted charge is calculated. The charge which is high enough to include the median of ranked submitted charges is the customary charge for that physician and for that procedure category. Although this would appear to be a method under which the provider could increase his customary charge by grouping visits or services, in reality because the charge would be overridden by the prevailing charge, the provider would be paid only for one of the services for which he billed. Therefore, in almost all cases, each service is submitted on an individual bill.

D. *Prevailing Charge Calculation*

Similarly to the procedure for calculating the customary charge, Medicare takes into account the number of services of a particular procedure category performed by a physician in calculating his prevailing charge. Thus, customary charges within a particular specialty group (i.e., Surgical Specialties, General Practice, and Medical Specialties) for a particular procedure are ranked and weighted by the number of services represented by each physician's customary charge. The customary charge high enough to include the 75th percentile service is chosen as the prevailing charge for that group of physicians and for that procedure. A minimum of four customary charges is required to calculate a prevailing charge.

For the study, as many as six prevailing charges are calculated for each specialty group and for each procedure code, one on the statewide basis, and one for each of the five localities. For those physicians who do not fall into any of the three specialty categories specified for this evaluation, prevailing charges are calculated on a localitywide and statewide basis, i.e., prevailing charges are calculated pooling all customary charges within a particular procedure category, regardless of specialty designation.

Although Medicaid prevailing charges are not calculated for this first year study (since Medicaid utilized Medicare prevailing charges during the first fee screen year of the study), the procedure for calculating a prevailing charge under the Medicaid program differs from that of Medicare in that customary charges are ranked regardless of the number of services represented, and the charge high enough to include the 75th percentile customary is the Medicaid prevailing charge. Only one customary charge is required to establish a Medicaid prevailing charge.

The simulations for the respective programs implement the above-described differences in methodologies for generating fee screens in Arkansas for Medicare and Medicaid.

E. Fee Screen Implementation and Pricing

Medicare fee screens are developed on claims for services provided during calendar year 1977 and are implemented on claims received during FSY 1979, the first fee screen year of the study (July 1, 1978 through June 30, 1979).

An idealized methodology, as close as possible to that utilized by Arkansas Medicaid, has been developed for this study. Thus, for the first year report, Medicaid customary charges are calculated on 1977 calender year Medicaid claims (utilizing the service date to delimit the calendar year), are compared to the 1977-based Medicare customary charges, and are implemented in the beginning of the second quarter of the fee screen year (i.e., in October 1978). Prevailing charges from Medicare are utilized throughout the year, and Medicare customary charges are utilized for the first quarter of the first fee screen year.

It is believed this procedure will reflect the methodology in practice as closely as is practicable without creating confounding influences in comparing the one-locality and multilocality systems for fee screen generation under each program.

F. Crossover Payments

For those patients eligible for both Medicare and Medicaid reimbursement, the crossover claims, the reasonable charge is determined by Medicare. Thus changes in the methodology for calculating reasonable charge impact program payments from Medicaid for the crossover claims. Arkansas Medicaid automatically pays the remaining 20 percent of the amount calculated as the reasonable charge by Medicare. It does not calculate a reasonable charge based on its own fee screens. Payments by both programs will be estimated, therefore, from the Medicare calculated reasonable charges only.

G Other Definitions

Several other terms applicable to the tabular presentations in the analysis section are presented below:

Actual payout. Total amount reported, for claims included in a particular designated category, under the "allowed amount" field for each program (i.e., Medicare and Medicaid). This figure is not corrected for deductibles.

The deductible is not subtracted from the payment, since there would be no difference in total deductible amount under a multilocality or single-locality contribution, and implementation of the deductible would be a costly process from a data processing point of view. The allowed amount includes 80 percent of the reasonable charge for Medicare and 100 percent of the reasonable charge for Medicaid.

Hospital follow-up visit and office follow-up visit. Two categories of service, 19023 and 19004, respectively, were selected for in-depth analysis since earlier research indicated these two categories had experienced the greatest impact from the change in locality structure (see memo from Jim Reed, op cit.).

Specialty groups. Broad categories of specialists, grouped together as "peers" for the purpose of developing prevailing charges for a particular locality. Only three "specialty groups," or "payment groups," are included in this analysis. The others have been excluded because of nonstandard methods for determining reasonable charge or, in the case of Osteopathy, because a reasonable interpretation of the category could not be determined. (See Appendix 1.)

Beneficiary liability. For that subpopulation of cases where the physician agrees to accept the reasonable charge calculated by Medicare as the total payment for service, i.e., the "assigned" cases, beneficiary liability will be calculated as 20 percent of the reasonable charge. For "unassigned" cases under Medicare, beneficiary liability will be calculated as total submitted charge less 80 percent of the calculated reasonable charge.

H. Advantages of the Methodology

The most basic advantage of the methodology developed for this evaluation (over the South Carolina methodology for evaluating the locality change for that State, the proposed approach submitted by Arkansas, and the SAW methodology) is that it most closely duplicates the legal requirements for calculating reasonable charge. Whereas the South Carolina design utilized the submitted charge and the prevailing charge only, the Arkansas design and preliminary analysis proposed utilizing the customary and prevailing charges only, and the SAW methodology utilizes customary charges only, the system described below utilizes all three of the basic inputs to determine reasonable charge and controls for extraneous factors which could influence the calculation of reasonable charge and the State's program payouts. At the same time, the methodology reflects some of the unique characteristics of the Arkansas system, even though an idealized procedure is used.

On the other hand, the system is general enough to be adapted for evaluations of other State systems, since the procedures being used to estimate impacts are general for all Medicare systems. The flexibility of the system can be appreciated in that it has been adapted also to the Medicaid program for Arkansas, which differs quite a bit from the Medicare system both in generation of fee screens and in the structure of the database utilized as input.

As in any secondary data analysis, i.e., where the data are collected for purposes other than those for which they are being used, the research is constrained by the data available, which have been collected for purposes other than the evaluation now underway. However, it shares the advantage of secondary analysis in that the data were not biased by the expectations and purposes of the agency collecting them. As a result, the investigator can have greater confidence in the objectivity of the final conclusions.

I. Constraints on the Methodology

1. Lack of an Economic Index for limiting rises in prevailing charges. No Economic Index could be developed with the data provided, since the Index is based on 1971 calendar year data. Had prevailing charges been available on a locality and statewide basis for a previous year (i.e., prior to the first fee screen year of the study), it would have been possible to calculate the limitation based on the charges. However, neither claims data nor prevailing charges appropriate for the purposes of calculating the Index were available; therefore, it could not be incorporated into the simulation. For the second year, further exploration of this constraint will be undertaken.

2. Crossover records on the Medicare database. It was discovered that Medicaid eligibility information could not be easily obtained from the Medicare databases. Therefore, after discussions with Arkansas dataprocessing staffs at Medicare and Medicaid, it was determined that the most efficient way of producing the required information relating to crossover claims would be to utilize the special Medicaid crossover subfile on such claims. Unfortunately, many irregularities have been uncovered with regard to the crossover database, e.g., a large number of claims are inadequately identified by procedure code for inclusion in the study and submitted charge data are inaccurate. Therefore, the crossover data are at best inadequate.

   The cross-reference between the CRVS and CPT coding systems utilized by Arkansas Medicare and Medicaid, respectively, is less than perfect, and many Medicaid claims are not priced with the use of customary and prevailing data during the study period. Therefore, the methodology utilized in this study reflects the procedure for pricing Medicaid claims, but does not include the large percentage of nonstandard pricing situations (at least 50 percent according to the Medicaid State Management Report of 10/78 through 9/79) which exist in practice under the Arkansas Medicaid program. The impact of this constraint will be discussed more fully in the Final Report.

The methodology developed for the simulation, therefore, is to some extent idealized. This approach is necessary in order to eliminate factors which would make it difficult, if not impossible, to evaluate the impact of change in the normal fee screen calculations on each of the programs and on the availability of medical services.

It must be kept in mind that the objective of the study is to compare single versus multilocality reimbursement. Therefore, factors which represent constants may be excluded from the simulation.

V

ANALYSIS

The following tables address the basic research questions for Medicare and Medicaid for fee screen year 1979, presenting comparisons for the two pricing processes: Multiple Area (i.e., 5-locality) and Statewide.

Figures produced through the simulation are presented in the tables for each of the five formerly-constituted geographic pricing areas, comparing the 5-locality to the statewide basis for computation in each of these areas. Comparative totals taken from the actual history tapes (non-simulated data) are presented as a check on how the overall simulated picture approximates the actual historical totals.

In the first six sets of Tables, simulated payouts in dollars (by quarters of FSY 1979) are presented for:

- Total Medicare payouts (Table I-A,-B,-C,-D)
- Total Medicaid payouts (Table II-A,-B,-C,-D)
- Beneficiary liability on assigned claims (Table III-A,-B,-C,-D)
- Beneficiary liability on unassigned claims (Table IV-A,-B,-C,-D)
- Medicare-Medicaid interface: Medicare share (Table V-A,-B,-C,-D)
- Medicare-Medicaid interface: Medicaid share (Table VI-A,-B,-C,-D)

The column headings in these tables break out the comparisons by the three medical specialty categories--Medical Specialties, General Practice, and Surgical Specialties--as appropriate, with totals for all physicians presented in the last column.

Other tables show yearly figures, utilizing the two-method simulation, for:

- Office follow-up visits (Table VII)
- Hospital follow-up visits (Table VIII)
- Distributions of type of charge selected as method of payment (Table IX-A [Medicare], IX-B [Medicaid], and IX-C [Medicare-Medicaid interface]) and
- Actual figures for assignment and nonassignment frequencies (Table X)

Tables XI-A,-B -C present actual (nonsimulated) findings for each of the formerly-constituted localities and for the State as a whole, on changes (1978-1980) in numbers of physicians and in population/physician ratios, and on physician movement among the five localities for the period October 1977-March 1979.

A. Total Medicare Payouts

Tables I-A, -B, -C, and -D present simulated and actual payouts for the four quarters of fee screen year 1979, beginning with the period July 1, 1978 through September 1978. Summing figures for Table I-A,-B,-C,-D for total Medicare payouts for the year shows that the simulation overestimates payout by about 4.2 percent. Given that the deductible is not calculated into the simulation and that the Economic Index is not used to limit the prevailing charges, this seems reasonable. Summing for all four quarters, total actual payout is $33,166,434, while estimated payouts using the simulation are $34,852,760 and $34,563,872 for multilocality and statewide simulations, respectively.

The four tables presenting total program payouts for Medicare encompass about 53 percent of the estimated total payout of $62,809,927. (The estimated total payout figure is calculated by summing the allowed amounts for all valid records on the raw data tapes which: 1) reflect a charge for a physician's service or services and 2) are for a type of service which was billed on a multilocality basis.) The four tables, therefore, represent the bulk of payouts for physicians' services under the Medicare program for fee screen year 1979.

Comparing the different localities, Locality 1 represents about 40 percent of total payouts. In all specialty categories, and in all quarters, Locality 1 claims utilizing multilocality simulation of fee screens resulted in higher payouts than when the statewide method was used. The reverse is true for total payouts for claims in the other four localities (but not for all specialty categories within all localities). However, because of the preponderance of payments associated with Locality 1, total payouts using the statewide methodology are lower than for multiple-area payouts. This pattern holds true for all four quarters of fee screen year 1979.

Therefore, the Medicare program costs, overall, are slightly reduced using the statewide methodology. This logically follows from the fact that charges for services in urban areas (such as Locality 1) can be expected to be somewhat higher than in rural areas (particularly Locality 5). Thus the prevailing charge will be higher for Locality 1 than for the other localities under the multi-locality system. When a statewide system is used, the prevailing charges for Locality 1 are reduced and the heavy contribution of that locality to all claims makes the total payouts lower.

It should be emphasized that the difference in total payout between the two methods is small--less than 1 percent (an .8 percent decrease is shown when the statewide simulation is used). The simulation indicates, therefore, that there is no reason to believe that converting from a multilocality to a statewide methodology for calculating prevailing fees increases payouts.

TABLE I-A

All Selected Medicare Claims
Payout in Dollars for Quarter 3 of Year 1978

		- PAYMENT GROUPS -				
CCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	1,490,164	493,345	719,918	762,833	3,466,261
	STATEWIDE	1,441,253	430,876	688,197	757,325	3,317,654
AREA 2	MULTIPLE AREA	550,488	418,754	560,033	12,242	1,541,519
	STATEWIDE	568,250	416,875	563,550	12,301	1,560,977
AREA 3	MULTIPLE AREA	127,068	425,513	178,947	1,646	733,176
	STATEWIDE	136,725	427,573	178,465	1,657	744,421
AREA 4	MULTIPLE AREA	270,773	911,025	240,201	1,388	1,423,389
	STATEWIDE	284,252	916,504	248,273	1,356	1,450,387
AREA 5	MULTIPLE AREA	10,355	1,169,683	53,398	5,332	1,238,770
	STATEWIDE	10,423	1,173,421	54,284	5,428	1,243,557
OVERALL	MULTIPLE AREA	2,448,849	3,418,321	1,752,500	783,443	8,403,115
	STATEWIDE	2,440,905	3,365,251	1,732,771	778,069	8,316,998
ACTUAL	HISTORY TAPES	2,210,369	3,330,044	1,685,698	778,061	8,004,175

TABLE I-B

All Selected Medicare Claims
Payout in Dollars for Quarter 4 of Year 1978

		- PAYMENT GROUPS -				
CATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	1,555,132	504,487	794,456	710,138	3,564,214
	STATEWIDE	1,503,486	439,887	758,198	705,816	3,407,387
AREA 2	MULTIPLE AREA	551,111	396,344	581,967	14,457	1,543,880
	STATEWIDE	573,123	395,509	585,137	14,464	1,568,234
AREA 3	MULTIPLE AREA	117,861	436,256	229,274	983	784,376
	STATEWIDE	128,230	438,996	229,015	1,017	797,259
REA 4	MULTIPLE AREA	270,775	907,639	263,686	2,465	1,444,567
	STATEWIDE	290,467	913,373	274,621	2,457	1,480,920
REA 5	MULTIPLE AREA	8,580	1,155,166	46,126	9,541	1,219,414
	STATEWIDE	8,604	1,159,393	45,912	9,620	1,223,530
VERALL	MULTIPLE AREA	2,503,461	3,399,893	1,915,513	737,585	8,556,453
	STATEWIDE	2,503,911	3,347,159	1,892,885	733,376	8,477,334
CTUAL	HISTORY TAPES	2,263,904	3,299,998	1,836,572	734,878	8,135,355

TABLE I-C

All Selected Medicare Claims
Payout in Dollars for Quarter 1 of Year 1979

		- PAYMENT GROUPS -				
OCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	1,640,403	501,992	740,050	680,531	3,562,977
	STATEWIDE	1,589,513	435,561	705,481	677,014	3,407,569
AREA 2	MULTIPLE AREA	597,885	405,617	553,476	17,600	1,574,578
	STATEWIDE	632,099	404,442	557,458	17,711	1,611,711
AREA 3	MULTIPLE AREA	127,233	461,650	193,252	3,503	785,640
	STATEWIDE	137,020	463,328	193,243	3,579	797,172
AREA 4	MULTIPLE AREA	280,326	1,006,953	243,074	3,602	1,533,957
	STATEWIDE	302,088	1,017,954	255,488	3,718	1,579,249
AREA 5	MULTIPLE AREA	8,805	1,284,775	61,518	11,162	1,366,261
	STATEWIDE	8,837	1,289,971	60,244	11,276	1,370,330
OVERALL	MULTIPLE AREA	2,654,652	3,660,989	1,791,372	716,400	8,823,416
	STATEWIDE	2,669,558	3,611,257	1,771,916	713,300	8,766,035
ACTUAL	HISTORY TAPES	2,411,643	3,575,939	1,726,864	713,131	8,427,580

TABLE I-D

All Selected Medicare Claims
Payout in Dollars for Quarter 2 of Year 1979

		- PAYMENT GROUPS -				
OCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	1,776,917	533,530	767,513	663,470	3,741,432
	STATEWIDE	1,718,870	458,922	729,951	659,221	3,566,965
AREA 2	MULTIPLE AREA	639,143	428,744	568,705	23,161	1,659,754
	STATEWIDE	678,188	426,568	572,829	23,326	1,700,912
AREA 3	MULTIPLE AREA	139,059	444,681	211,846	1,467	797,055
	STATEWIDE	151,202	447,955	211,571	1,502	812,231
AREA 4	MULTIPLE AREA	299,201	995,629	267,676	15,193	1,577,700
	STATEWIDE	319,763	1,006,370	282,119	14,759	1,623,013
AREA 5	MULTIPLE AREA	9,485	1,220,345	51,251	12,750	1,293,833
	STATEWIDE	9,449	1,224,822	53,125	12,984	1,300,382
OVERALL	MULTIPLE AREA	2,863,806	3,622,931	1,866,994	716,044	9,069,776
	STATEWIDE	2,877,473	3,564,638	1,849,597	711,793	9,003,505
ACTUAL	HISTORY TAPES	2,589,581	3,507,368	1,791,591	710,779	8,599,324

B. Total Medicaid Payouts

Tables II-A,-B,-C,-D present simulated and actual payouts for each quarter of FSY 1979 for Medicaid. "Actual" figures presented in each Table are summed from the allowed amounts on the raw data tapes recorded for each charge included in this analysis.

Totals of allowed amounts for all appropriate records were computed for FSY 1979, giving $11,584,911. Summing for all four quarters, represented by Table II-A,-B,-C,-D, produces a total of $5,888,790 in payouts, or about 50.83 percent of total payouts for physicians' services is included in the study. These figures do not include payouts for crossover records, which are presented below. (Medicare payouts, however, do include crossover payouts.)

Although totaling across all four quarters for actual charges and simulated statewide charges show a difference of about 5.6 percent, it should be pointed out that there is a wide discrepancy between Table II-A and the other three Tables in this set. The first quarter, during which time only Medicare fee screens were used, shows a difference of 13.8 percent, while the subsequent quarters show differences of 4.9 percent (Table II-B), 2.2 percent (Table II-C), and 4.6 percent (Table II-D). It must be recalled that Medicaid customary charges, based on 1977 data, were implemented for the last three quarters of FSY 1979. The Arkansas State Management Report, covering most of the first fee screen year of this study, reported that the wrong Medicare prevailing charges were implemented by Medicaid in Arkansas during this period, due to a mistake in reading Medicare records containing prevailing charges. Therefore, this large difference in the first quarter probably reflects the use, by Medicaid, of the inappropriate prevailing charges and the probable greater use of prevailing charges during this period, since Medicaid customary charges had not yet been implemented. Because Medicaid customary charges were not used in the first quarter, for many Medicaid physicians a customary charge was probably not available (since only physicians providing services under both programs would have had customary charges). Therefore, the comparison for determining a reasonable charge would be between the inappropriate prevailing charge and the submitted charge.

The simulation indicates that payouts under the statewide methodology would be about 3 percent lower than under the multilocality method. This is significantly different ($346,257). Each of the four quarters reflects a similar pattern. It can be stated, therefore, that for the Medicaid program, a significant reduction in payouts can be observed by converting to the statewide methodology.

TABLE II-A

All Selected Medicaid Claims
Payout in Dollars for Quarter 3 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	141,324	72,744	72,646	24,593	311,309
	STATEWIDE	138,163	65,001	68,897	24,115	296,177
AREA 2	MULTIPLE AREA	62,970	66,480	118,144	29,589	277,085
	STATEWIDE	63,235	66,336	82,498	31,115	243,184
AREA 3	MULTIPLE AREA	29,520	187,699	39,605	8,910	265,735
	STATEWIDE	11,525	192,240	40,883	8,819	253,468
AREA 4	MULTIPLE AREA	71,227	214,627	38,041	8,804	332,700
	STATEWIDE	68,061	220,523	40,413	8,716	337,714
AREA 5	MULTIPLE AREA	7,346	282,008	13,847	1,306	304,508
	STATEWIDE	4,983	283,167	11,544	1,288	300,982
OVERALL	MULTIPLE AREA	312,289	823,560	282,285	73,204	1,491,339
	STATEWIDE	285,968	827,268	244,236	74,055	1,431,528
ACTUAL	HISTORY TAPES	239,972	739,983	217,585	68,319	1,265,861

TABLE II-B

All Selected Medicaid Claims
Payout in Dollars for Quarter 4 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	139,316	76,977	80,142	24,120	320,557
	STATEWIDE	137,113	68,761	76,475	23,610	305,960
AREA 2	MULTIPLE AREA	75,200	59,824	93,568	30,657	259,250
	STATEWIDE	72,899	59,672	70,976	32,714	236,263
AREA 3	MULTIPLE AREA	12,135	178,236	38,827	7,511	236,711
	STATEWIDE	11,306	181,619	39,734	8,102	240,762
AREA 4	MULTIPLE AREA	67,415	222,466	33,725	9,184	332,791
	STATEWIDE	64,292	226,564	36,086	9,054	335,997
AREA 5	MULTIPLE AREA	6,308	298,636	15,309	3,635	323,889
	STATEWIDE	6,309	300,002	9,751	3,615	319,677
OVERALL	MULTIPLE AREA	300,375	836,140	261,573	75,110	1,473,200
	STATEWIDE	291,919	836,620	233,024	77,097	1,438,661
ACTUAL	HISTORY TAPES	268,318	808,751	220,603	73,245	1,370,919

TABLE II-C

All Selected Medicaid Claims
Payout in Dollars for Quarter 1 of Year 1979

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	160,775	88,506	93,239	21,631	364,152
	STATEWIDE	157,660	78,192	87,770	21,393	345,017
AREA 2	MULTIPLE AREA	97,333	63,428	99,919	37,556	298,237
	STATEWIDE	86,960	63,075	82,329	38,675	271,040
AREA 3	MULTIPLE AREA	30,490	212,300	35,075	9,441	287,308
	STATEWIDE	24,503	215,464	36,271	9,660	285,899
AREA 4	MULTIPLE AREA	85,957	243,293	36,894	9,301	375,446
	STATEWIDE	81,680	248,490	38,833	9,289	378,293
AREA 5	MULTIPLE AREA	5,675	311,299	19,486	7,102	343,562
	STATEWIDE	5,666	312,834	12,819	7,129	338,449
OVERALL	MULTIPLE AREA	380,231	918,828	284,614	85,032	1,668,707
	STATEWIDE	356,471	918,057	258,023	86,147	1,618,699
ACTUAL	HISTORY TAPES	342,572	905,678	252,593	82,375	1,583,219

TABLE II-D

All Selected Medicaid Claims
Payout in Dollars for Quarter 2 of Year 1979

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	197,810	104,099	105,702	24,922	432,535
	STATEWIDE	194,484	89,179	98,837	24,249	406,751
AREA 2	MULTIPLE AREA	84,840	66,243	101,353	48,540	300,978
	STATEWIDE	89,445	65,759	83,191	48,974	287,370
AREA 3	MULTIPLE AREA	56,400	198,516	36,661	11,775	303,353
	STATEWIDE	34,207	202,270	37,357	12,187	286,022
AREA 4	MULTIPLE AREA	84,940	255,068	39,881	12,007	391,898
	STATEWIDE	90,379	261,606	42,647	11,905	406,538
AREA 5	MULTIPLE AREA	7,365	332,545	16,395	8,217	364,523
	STATEWIDE	7,319	334,059	9,890	8,207	359,476
OVERALL	MULTIPLE AREA	431,357	956,473	299,995	105,464	1,793,290
	STATEWIDE	415,836	952,875	271,923	105,523	1,746,159
ACTUAL	HISTORY TAPES	373,668	931,215	265,363	98,544	1,668,791

C. Beneficiary Liability - Assigned Claims

Beneficiary liability for assigned claims consists of 20 percent of the reasonable charge (less any outstanding deductible) in those cases where the physician agrees to accept, as total payment, the reasonable charge.

Tables III-A,-B,-C,-D present quarterly total liabilities for those cases where the physician has accepted assignment.

As could be expected, the beneficiary liability figures parallel, in most cases, those for total payouts. Since beneficiary liability is defined as 20 percent of the reasonable charge, if the reasonable charge is higher the payout will be higher and, therefore, the assigned beneficiary liability will be higher. Total figures for the multilocality simulation ($4,345,291) and the statewide simulation ($4,190,346) show that beneficiary liability for assigned claims under the statewide methodology is slightly (1.3 percent) less than under the multilocality methodology.

The overall decrease in payout under the statewide simulation for beneficiary liability for assigned claims can be attributed almost entirely (considering all cells and all quarters of the year) to the decrease in Locality 1. In each of the other localities the total (All physicians) payout is slightly greater with the statewide system, and this pattern holds for all quarters of FSY 1979. The overall decreases appear to be most consistent for Medical Specialties and General Practice.

Comparing the simulated statewide payouts to actual payouts, the simulation overestimates the actual payout by about 3.1 percent. Total payout under the statewide simulation is $4,320,240, while the actual payout figure is $4,190,346. Given the lack of a deductible, this is a small amount.

TABLE III-A

Beneficiary Liability - Assigned Claims
Payout in Dollars for Quarter 3 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	127,503	48,614	81,834	111,195	369,147
	STATEWIDE	123,108	43,037	77,932	110,834	354,912
AREA 2	MULTIPLE AREA	57,002	53,474	53,357	450	164,284
	STATEWIDE	58,483	53,110	53,598	456	165,647
AREA 3	MULTIPLE AREA	16,135	74,542	31,623	305	122,606
	STATEWIDE	17,462	74,822	31,571	308	124,164
AREA 4	MULTIPLE AREA	38,037	127,761	31,556	166	197,521
	STATEWIDE	39,045	128,432	32,688	157	200,324
AREA 5	MULTIPLE AREA	428	179,897	7,704	570	188,600
	STATEWIDE	427	180,449	7,631	568	189,076
OVERALL	MULTIPLE AREA	239,107	484,289	206,075	112,687	1,042,160
	STATEWIDE	238,527	479,851	203,421	112,325	1,034,125
ACTUAL	HISTORY TAPES	220,744	475,826	197,298	112,601	1,006,471

TABLE III-B

Beneficiary Liability - Assigned Claims
Payout in Dollars for Quarter 4 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	141,424	49,206	87,173	110,135	387,939
	STATEWIDE	136,583	43,317	83,046	109,854	372,802
AREA 2	MULTIPLE AREA	57,291	45,655	55,540	601	159,088
	STATEWIDE	59,091	45,551	55,831	587	161,061
AREA 3	MULTIPLE AREA	15,035	75,528	43,901	180	134,645
	STATEWIDE	16,645	75,963	43,932	188	136,729
AREA 4	MULTIPLE AREA	39,232	117,778	30,950	357	188,319
	STATEWIDE	41,655	118,545	32,100	351	192,653
AREA 5	MULTIPLE AREA	554	178,197	5,456	1,052	185,260
	STATEWIDE	556	178,822	5,360	1,056	185,796
OVERALL	MULTIPLE AREA	253,538	466,366	223,020	112,327	1,055,252
	STATEWIDE	254,532	462,201	220,272	112,038	1,049,044
ACTUAL	HISTORY TAPES	233,866	457,073	213,290	112,465	1,016,695

TABLE III-C

Beneficiary Liability - Assigned Claims
Payout in Dollars for Quarter 1 of Year 1979

		- PAYMENT GROUPS -				
OCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	153,767	53,659	83,517	109,338	400,282
	STATEWIDE	148,360	46,617	79,349	109,050	383,376
AREA 2	MULTIPLE AREA	59,623	48,751	53,947	793	163,115
	STATEWIDE	62,216	48,580	54,246	785	165,828
AREA 3	MULTIPLE AREA	17,051	84,649	36,341	500	138,542
	STATEWIDE	18,398	84,842	36,391	500	140,133
AREA 4	MULTIPLE AREA	40,855	140,924	28,733	344	210,857
	STATEWIDE	43,613	142,694	30,552	341	217,201
AREA 5	MULTIPLE AREA	586	202,535	8,372	904	212,398
	STATEWIDE	590	203,247	8,131	913	212,881
OVERALL	MULTIPLE AREA	271,884	530,519	210,911	111,880	1,125,196
	STATEWIDE	273,178	525,980	208,671	111,590	1,119,421
ACTUAL	HISTORY TAPES	250,659	522,696	202,934	111,435	1,087,730

TABLE III-D

Beneficiary Liability - Assigned Claims
Payout in Dollars for Quarter 2 of Year 1979

		- PAYMENT GROUPS -				
CATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
REA 1	MULTIPLE AREA	169,517	50,715	76,438	100,434	397,105
	STATEWIDE	163,539	43,171	72,335	99,972	379,019
REA 2	MULTIPLE AREA	68,331	50,947	55,218	939	175,437
	STATEWIDE	71,553	50,552	55,510	946	178,563
REA 3	MULTIPLE AREA	19,782	75,717	39,871	300	135,671
	STATEWIDE	21,717	76,205	39,878	309	138,111
REA 4	MULTIPLE AREA	41,787	136,957	36,435	2,803	217,984
	STATEWIDE	44,542	138,650	38,636	2,728	224,598
REA 5	MULTIPLE AREA	398	187,581	7,414	1,090	196,485
	STATEWIDE	388	188,213	7,646	1,109	197,357
VERALL	MULTIPLE AREA	299,817	501,919	215,377	105,568	1,122,683
	STATEWIDE	301,741	496,833	214,006	105,067	1,117,650
CTUAL	HISTORY TAPES	276,409	490,931	206,844	105,264	1,079,450

D. *Beneficiary Liability - Unassigned Claims*

Unassigned claims produce patterns that are almost mirror images of those for assigned claims. This is understandable in that, where the physician decides not to accept assignment for a claim, the beneficiary must pick up the balance. Thus it can be anticipated that where prevailing charges are lower (as under statewide computation conditions in Locality 1) and calculated reasonable charge totals are therefore lower, the beneficiary will have to pay a larger proportion of the total charge submitted by the physician.

Whereas the assigned claims can be expected to reflect the size of the fee screens, the unassigned claims can be expected to reflect the difference between the size of the fee screen and the submitted charge. Hence, where prevailing charges are lower, beneficiary liability will be higher for unassigned claims (while the reverse is true for assigned claims).

Tables IV-A,-B,-C,-D reflect this pattern. Summing for all four quarters, the statewide simulation underestimates the actual payout by about 9.2 percent. The simulation underestimates for each of the specialty groups and for each quarter consistently. Examining the two simulation methods, the total of $8,158,274 for the multilocality simulated payout is 2.3 percent lower than the $8,346,348 statewide simulated payout.

Summing the statewide and multilocality simulated liabilities for both assigned and unassigned claims obtains totals of $12,503,565 for the multilocality methodology, and $12,666,588 for the statewide methodology, a difference of $163,023, or about 1 percent.

It can be concluded, therefore, that there is no reason to believe that going from a multilocality to a statewide methodology for calculating prevailing charges would result in any significant increase overall to the beneficiaries in terms of their payout.

TABLE IV-A

Beneficiary Liability - Unassigned Claims
Payout in Dollars for Quarter 3 of Year 1978

		- PAYMENT GROUPS -				
CATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
REA 1	MULTIPLE AREA	396,225	138,073	167,850	132,531	834,679
	STATEWIDE	427,516	178,162	183,912	136,595	926,187
REA 2	MULTIPLE AREA	130,696	94,130	155,109	4,391	384,327
	STATEWIDE	118,858	94,554	152,556	4,353	370,322
REA 3	MULTIPLE AREA	27,904	53,339	19,757	170	101,171
	STATEWIDE	23,556	52,396	20,031	172	96,156
REA 4	MULTIPLE AREA	50,904	190,369	53,100	224	294,599
	STATEWIDE	41,457	187,608	49,557	223	278,847
REA 5	MULTIPLE AREA	2,720	181,922	11,044	1,408	197,095
	STATEWIDE	2,645	180,423	9,866	1,307	194,242
VERALL	MULTIPLE AREA	608,451	657,834	406,861	138,726	1,811,874
	STATEWIDE	614,032	693,146	415,924	142,651	1,865,755
CTUAL	HISTORY TAPES	771,631	706,898	436,907	143,769	2,059,207

TABLE IV-B

Beneficiary Liability - Unassigned Claims
Payout in Dollars for Quarter 4 of Year 1978

		- PAYMENT GROUPS -				
CATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
REA 1	MULTIPLE AREA	408,115	148,126	197,152	115,591	869,026
	STATEWIDE	440,392	189,042	216,870	118,791	965,096
REA 2	MULTIPLE AREA	138,838	101,825	170,914	4,951	416,530
	STATEWIDE	124,025	102,244	168,926	4,887	400,082
REA 3	MULTIPLE AREA	25,728	58,657	19,672	104	104,163
	STATEWIDE	21,799	57,656	20,057	101	99,615
REA 4	MULTIPLE AREA	50,529	211,601	72,112	415	334,658
	STATEWIDE	40,529	208,928	65,778	398	315,635
REA 5	MULTIPLE AREA	1,980	183,329	11,210	2,240	198,760
	STATEWIDE	1,964	181,620	11,043	2,178	196,806
VERALL	MULTIPLE AREA	625,192	703,539	471,103	123,303	1,923,138
	STATEWIDE	628,711	739,491	482,675	126,357	1,977,236
CTUAL	HISTORY TAPES	784,346	760,578	509,321	126,565	2,180,811

TABLE IV-C

Beneficiary Liability - Unassigned Claims
Payout in Dollars for Quarter 1 of Year 1979

LOCATION	PRICING METHOD	PAYMENT GROUPS - MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	433,134	148,202	196,871	114,455	892,664
	STATEWIDE	462,399	186,350	214,711	116,820	980,281
AREA 2	MULTIPLE AREA	173,078	114,789	173,104	6,396	467,368
	STATEWIDE	149,249	115,280	170,334	6,253	441,118
AREA 3	MULTIPLE AREA	26,998	56,858	20,860	621	105,378
	STATEWIDE	22,597	55,990	21,072	546	100,206
AREA 4	MULTIPLE AREA	55,530	242,246	71,184	1,029	369,990
	STATEWIDE	44,800	238,323	66,048	902	350,075
AREA 5	MULTIPLE AREA	2,280	222,260	12,282	3,340	240,164
	STATEWIDE	2,262	219,918	12,591	3,262	238,035
OVERALL	MULTIPLE AREA	691,022	784,397	474,303	125,843	2,075,566
	STATEWIDE	681,309	815,862	484,758	127,785	2,109,716
ACTUAL	HISTORY TAPES	847,598	833,388	505,331	127,348	2,313,666

TABLE IV-D

Beneficiary Liability - Unassigned Claims
Payout in Dollars for Quarter 2 of Year 1979

LOCATION	PRICING METHOD	PAYMENT GROUPS - MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	498,399	180,796	228,331	132,752	1,040,279
	STATEWIDE	532,526	225,018	249,417	135,154	1,142,117
AREA 2	MULTIPLE AREA	187,988	128,675	188,188	8,460	513,313
	STATEWIDE	161,900	129,269	185,244	8,325	484,740
AREA 3	MULTIPLE AREA	27,857	74,299	25,857	85	128,100
	STATEWIDE	23,453	72,981	26,159	89	122,684
AREA 4	MULTIPLE AREA	63,175	262,503	72,886	1,479	400,044
	STATEWIDE	53,632	258,702	67,246	1,614	381,195
AREA 5	MULTIPLE AREA	2,723	247,071	11,974	4,190	265,960
	STATEWIDE	2,720	245,123	11,027	4,033	262,904
OVERALL	MULTIPLE AREA	780,144	893,346	527,237	146,969	2,347,696
	STATEWIDE	774,233	931,094	539,096	149,217	2,393,641
ACTUAL	HISTORY TAPES	959,167	960,271	566,895	151,019	2,637,353

E. Medicare - Medicaid Interface : Medicare Share

Total payouts for the Medicare program for charges eligible for payment by both the Medicare and Medicaid programs, i.e., the crossover cases, are presented in Tables V-A,-B,-C,-D for each of the four quarters of FSY 1979. Records for the analysis of this element of the Medicare and Medicaid systems were obtained from Medicaid, but were originally supplied to Medicaid by Medicare. Total "Allowed" amounts represent the amount to be remitted by Medicaid, i.e., usually 20 percent of the reasonable charge calculated by Medicare. Allowed amounts taken from the raw data tapes have been multiplied by four to estimate the Medicare 80 percent portion of the total payments.

Comparison of total figures, summing across all quarters, shows that the statewide simulation underestimates total payouts indicated by the history tapes by about 24 percent, i.e., the difference of $1,929,682 between the simulated total for statewide calculations ($6,072,814) and the actual total ($8,002,496). Examination of each of the four Tables shows a consistently low simulated payout, in comparision with the actual charges, in the General Practice specialty group category. Other specialty groups show a mixed pattern. For Table V-A, the statewide simulation has produced a simulated payout 32 percent lower than the actual payout; for Table V-B, a simulated payout 18 percent lower; Table V-C, 42 percent lower; and Table V-D, 42 percent lower.

ABCBS data processing personnel report that with Optimum Systems, which processed the crossover records in 1978 and 1979, many irregularities existed in the database. Therefore, they could not shed much light on what might have been included in particular fields on crossover claims during the first year and one-half of the study period (FSY 1979 and the first half of FSY 1980) when Optimum Systems processed the crossover claims for the Medicare program.

Simulated figures for crossover payouts show a similar pattern to those for Medicare and Medicaid payouts, as might be expected.

Summing for all four quarters, total payout under the multilocality method ($6,337,518) would be reduced by 4 percent under the statewide methodology ($6,072,814). This is a significant difference ($264,704) in total program payouts for this portion of the Medicare program.

TABLE V-A

Medicare Share of Crossover Claims
Payout in Dollars for Quarter 3 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	72,410	61,459	71,790	113,088	318,749
	STATEWIDE	69,605	55,253	66,730	97,332	288,922
AREA 2	MULTIPLE AREA	36,570	38,451	29,963	21,959	126,944
	STATEWIDE	38,751	37,733	29,782	14,827	121,095
AREA 3	MULTIPLE AREA	26,029	99,613	29,213	42,819	197,675
	STATEWIDE	12,116	100,277	27,095	50,206	189,697
AREA 4	MULTIPLE AREA	30,574	169,758	36,990	87,152	324,476
	STATEWIDE	19,434	170,670	39,328	87,743	317,176
AREA 5	MULTIPLE AREA	1,393	301,827	14,024	54,345	372,091
	STATEWIDE	2,020	303,660	12,010	58,394	376,084
OVERALL	MULTIPLE AREA	167,473	671,110	181,982	319,365	1,339,936
	STATEWIDE	141,923	667,596	174,946	308,504	1,292,975
ACTUAL	HISTORY TAPES	143,252	990,696	176,932	327,020	1,637,908

TABLE V-B

Medicare Share of Crossover Claims
Payout in Dollars for Quarter 4 of Year 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	80,075	66,007	62,647	126,238	334,969
	STATEWIDE	77,262	58,304	58,420	108,710	302,698
AREA 2	MULTIPLE AREA	40,593	39,776	43,344	12,303	136,018
	STATEWIDE	42,845	39,284	43,076	12,786	137,992
AREA 3	MULTIPLE AREA	29,029	103,631	37,964	71,232	241,358
	STATEWIDE	13,433	104,409	38,112	71,883	227,838
AREA 4	MULTIPLE AREA	25,391	184,955	38,321	89,828	338,496
	STATEWIDE	27,463	186,318	39,800	92,272	345,855
AREA 5	MULTIPLE AREA	2,456	326,932	20,740	66,999	417,129
	STATEWIDE	2,454	328,502	17,654	72,291	420,902
OVERALL	MULTIPLE AREA	177,547	721,303	203,017	366,602	1,468,472
	STATEWIDE	163,459	716,819	197,063	357,944	1,435,287
ACTUAL	HISTORY TAPES	144,252	880,840	176,164	324,816	1,526,080

TABLE V-C

Medicare Share of Crossover Claims
Payout in Dollars for Quarter 1 of Year 1979

		- PAYMENT GROUPS -				
OCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	98,759	79,574	73,565	129,273	381,172
	STATEWIDE	94,741	68,944	67,606	111,116	342,409
AREA 2	MULTIPLE AREA	55,533	49,130	50,007	23,479	178,155
	STATEWIDE	55,037	48,464	43,817	26,564	173,383
AREA 3	MULTIPLE AREA	45,348	146,056	49,509	62,315	303,230
	STATEWIDE	15,879	147,188	28,167	73,037	264,273
AREA 4	MULTIPLE AREA	30,435	224,923	32,074	79,505	366,939
	STATEWIDE	33,051	228,842	34,470	82,758	379,122
AREA 5	MULTIPLE AREA	3,926	379,285	46,133	65,867	495,213
	STATEWIDE	4,227	381,176	22,047	71,812	479,263
OVERALL	MULTIPLE AREA	234,008	878,970	251,290	360,441	1,724,710
	STATEWIDE	202,937	874,616	196,109	365,289	1,638,952
ACTUAL	HISTORY TAPES	256,444	1,530,224	224,204	443,428	2,454,304

TABLE V-D

Medicare Share of Crossover Claims
Payout in Dollars for Quarter 2 of Year 1979

		- PAYMENT GROUPS -				
OCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	105,886	93,843	93,769	136,133	429,633
	STATEWIDE	102,019	76,147	87,962	118,320	384,450
AREA 2	MULTIPLE AREA	77,566	46,057	40,986	21,429	186,039
	STATEWIDE	58,206	45,158	40,152	19,685	163,203
AREA 3	MULTIPLE AREA	39,727	110,055	74,469	88,118	312,370
	STATEWIDE	19,295	110,853	64,538	96,007	290,694
AREA 4	MULTIPLE AREA	61,865	204,311	44,762	84,455	395,394
	STATEWIDE	55,756	208,408	49,215	91,190	404,571
AREA 5	MULTIPLE AREA	3,352	347,943	56,994	72,672	480,962
	STATEWIDE	3,354	349,530	29,408	80,387	462,680
OVERALL	MULTIPLE AREA	288,398	802,211	310,981	402,808	1,804,400
	STATEWIDE	239,632	790,098	271,277	405,591	1,705,600
ACTUAL	HISTORY TAPES	269,776	1,384,892	252,656	476,872	2,384,204

F. Medicare - Medicaid Interface: Medicaid Share

Mirroring the Medicare crossover payouts, Tables VI-A,-B,-C,-D show the Medicaid payout figures. Medicaid payouts are defined to be 20 percent of the total reasonable charge calculated by Medicare. Therefore, the same anomalies and observations can be made of the Medicaid share of crossover payouts as can be made of the Medicare share.

It has been noted above that, unlike the Medicare total program payouts, Medicaid crossover payouts are not included in Medicaid total payouts. They have not been added in for this analysis due to the anomalies of the crossover database described by the Medicaid staff.

Medicaid crossover records include $2,000,624 in program payouts--about 50.5 percent of the total payout for valid claims for physicians' services ($3,963,094) for the crossover database. Therefore, by summing the total payouts for Medicaid crossover claims included in this study, we obtain a figure of $7,889,414 ($5,888,790 + $2,000,624) total payout under the Medicaid program.

The crossover file, however, contains procedure codes which are included in the Medicare analysis but not in the Medicaid analysis (see Appendix II). Therefore, it would not be legitimate to collapse the Medicaid and crossover payouts into one total for this study. As a result, crossover payouts have been kept separate from other Medicaid program payouts.

In sum, Medicaid crossover data and Medicare payout Tables for crossover records indicate a significantly lower payout with the statewide methodology than with the multilocality methodology.

TABLE VI-A

Medicaid Share of Crossover Claims
Payout in Dollars for Quarter 3 of 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	18,102	15,365	17,947	28,272	79,687
	STATEWIDE	17,401	13,813	16,682	24,333	72,230
AREA 2	MULTIPLE AREA	9,142	9,613	7,491	5,490	31,736
	STATEWIDE	9,688	9,433	7,445	3,707	30,274
AREA 3	MULTIPLE AREA	6,507	24,903	7,303	10,705	49,419
	STATEWIDE	3,029	25,069	6,945	12,551	47,424
AREA 4	MULTIPLE AREA	7,643	42,439	9,247	21,788	81,119
	STATEWIDE	4,858	42,667	9,832	21,936	79,294
AREA 5	MULTIPLE AREA	473	75,457	3,506	13,586	93,023
	STATEWIDE	505	75,915	3,002	14,598	94,021
OVERALL	MULTIPLE AREA	41,869	167,777	45,495	79,841	334,984
	STATEWIDE	35,482	166,899	43,736	77,126	323,244
ACTUAL HISTORY TAPES		35,813	247,674	44,233	81,755	409,477

TABLE VI-B

Medicaid Share of Crossover Claims
Payout in Dollars for Quarter 4 of 1978

		- PAYMENT GROUPS -				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	20,019	16,502	15,662	31,559	83,742
	STATEWIDE	19,315	14,576	14,605	27,177	75,674
AREA 2	MULTIPLE AREA	10,148	9,944	10,836	3,076	34,004
	STATEWIDE	10,711	9,821	10,769	3,196	34,498
AREA 3	MULTIPLE AREA	7,257	25,908	9,491	17,808	60,464
	STATEWIDE	6,866	26,102	9,528	17,971	56,959
AREA 4	MULTIPLE AREA	614	46,239	9,580	22,457	84,624
	STATEWIDE	613	46,579	9,950	23,068	86,464
AREA 5	MULTIPLE AREA	44,387	81,733	5,185	16,750	104,282
	STATEWIDE	40,865	82,125	4,413	18,073	105,225
OVERALL	MULTIPLE AREA	44,387	180,326	50,754	91,650	336,118
	STATEWIDE	40,865	179,205	49,266	89,486	358,822
ACTUAL HISTORY TAPES		36,063	220,210	44,041	81,204	381,520

TABLE VI-C

Medicaid Share of Crossover Claims
Payout in Dollars for Quarter 1 of 1979

		PAYMENT GROUPS				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	24,690	19,893	18,391	32,318	95,293
	STATEWIDE	23,685	17,236	16,901	27,779	85,602
AREA 2	MULTIPLE AREA	13,884	12,282	12,502	5,870	44,539
	STATEWIDE	13,759	12,116	10,954	6,641	43,471
AREA 3	MULTIPLE AREA	11,337	36,514	12,377	15,579	75,807
	STATEWIDE	3,970	36,797	7,042	18,259	66,068
AREA 4	MULTIPLE AREA	7,609	56,231	8,018	19,876	91,735
	STATEWIDE	8,263	57,210	8,617	20,689	94,780
AREA 5	MULTIPLE AREA	981	94,821	11,533	16,467	123,803
	STATEWIDE	2,057	95,294	5,512	17,953	119,816
OVERALL	MULTIPLE AREA	58,502	219,742	62,822	90,110	431,177
	STATEWIDE	50,734	218,654	49,027	91,322	409,738
ACTUAL HISTORY TAPES		64,111	382,556	56,051	110,857	613,576

TABLE VI-D

Medicaid Share of Crossover Claims
Payout in Dollars for Quarter 2 of 1979

		PAYMENT GROUPS				
LOCATION	PRICING METHOD	MEDICAL SPECIALTIES	GENERAL PRACTICE	SURGICAL SPECIALTIES	OTHER PHYSICIANS	TOTAL, ALL PHYSICIANS
AREA 1	MULTIPLE AREA	26,471	23,461	23,442	34,033	107,408
	STATEWIDE	25,505	19,037	21,990	29,580	96,112
AREA 2	MULTIPLE AREA	19,391	11,514	10,246	5,357	46,510
	STATEWIDE	14,551	11,289	10,038	4,921	40,801
AREA 3	MULTIPLE AREA	9,932	27,514	18,617	22,029	78,092
	STATEWIDE	4,824	27,713	16,134	24,002	72,673
AREA 4	MULTIPLE AREA	15,466	51,078	11,190	21,114	98,848
	STATEWIDE	13,939	52,102	12,304	22,797	101,143
AREA 5	MULTIPLE AREA	838	86,986	14,248	18,168	120,240
	STATEWIDE	838	87,382	7,352	20,097	115,670
OVERALL	MULTIPLE AREA	72,099	200,553	77,745	100,702	451,100
	STATEWIDE	59,658	197,524	67,819	101,398	426,400
ACTUAL HISTORY TAPE		67,444	346,223	63,164	119,218	596,051

G. Office Follow-up Visit

Table VII provides a microcosm of the analysis of total payouts and liabilities for the single procedure code for Office Follow-up Visit (CRVS code 19004) It can be observed that the prevailing charge for Locality 1, the most urban locality, is also the highest under the multilocality simulation ($15). The reasonable charge, calculated by taking the total dollar payout for each of the categories and dividing by the number of services for the category, also reflects the urban-rural continuum represented in the locality system. Thus, the highest reasonable charge is recorded for Locality 1, and the lowest for Locality 5.

Looking at the assigned cases under the Medicare program, the simulation overestimates the payout, in comparison with the actual payout figure, by 10.6 percent. The simulation shows a slightly lower payout for the beneficiary under the statewide methodology; however, the difference is only .5 percent, which is insignificant.

For unassigned cases, a 3.1 percent increase in beneficiary liability can be observed. The statewide simulation underestimates actual beneficiary payout figures by 21.5 percent.

Like the Medicare simulation, the Medicaid simulation shows essentially no difference between the multilocality and statewide methodologies in total payouts (.1 percent difference). (It should be remembered that all Medicaid claims are assigned.) The simulation overestimates the actual payout for the Medicaid program by 3.1 percent.

For crossover payouts, the two methods show no significant difference (.7 percent). The statewide simulation underestimates actual payout by 46.8 percent, a very large discrepancy. Problems with the crossover file have been discussed earlier.

Special Report: Office Follow-up Visit in Dollars
Fee Screen Year 1979

Locality	Prevailing Charge*	Weighted Average Reasonable Charge	MEDICARE				MEDICAID	CROSSOVERS	
			Assigned		Unassigned				
			Program Payout	Beneficiary Liability	Program Payout	Beneficiary Liability	Program Payout	Medicare	Medicaid
AREA 1									
Multilocality	15.00	9.00	320,528	80,132	819,035	375,853	165,649	107,554	26,888
Statewide		8.40	299,028	74,757	763,869	431,019	159,565	103,775	25,944
AREA 2									
Multilocality	12.00	7.78	283,504	70,876	673,898	312,052	135,157	71,935	17,984
Statewide		7.78	283,504	70,876	673,898	312,052	135,157	71,935	17,984
AREA 3									
Multilocality	10.00	7.37	361,624	90,406	174,322	76,751	157,894	143,911	35,978
Statewide		7.48	364,808	91,202	178,644	72,430	158,661	144,372	36,093
AREA 4									
Multilocality	10.00	7.02	650,936	162,734	648,185	300,469	400,186	298,187	74,547
Statewide		7.09	656,860	164,215	657,354	291,304	406,518	298,616	74,654
AREA 5									
Multilocality	10.00	6.83	759,012	189,753	680,584	279,130	339,537	408,307	102,077
Statewide		6.83	759,160	189,790	681,357	271,578	339,648	409,077	102,269
ALL									
Multilocality		7.47	2,375,624	593,906	2,942,867	1,337,477	1,198,428	1,034,898	258,724
Statewide	12.00	7.41	2,363,388	590,847	2,955,094	1,378,391	1,200,054	1,027,779	256,945
Actual History Tapes	Total Payout $4,710,538			Total Assigned Liability $534,415		Total Unassigned Liability $1,756,223	Total Payout $1,163,472	Total Payout $1,932,764	Total Payout $483,191

*Prevailing charges are localitywide.

H. Hospital Follow-up Visit

Table VIII presents an intensive analysis of the Hospital Follow-up Visit procedure (CRVS 19023). Discrepancies between simulations and estimates are much smaller for this category than for Office Follow-up Visit for the statewide crossover simulation, which overestimates actual payouts by 9.5 percent. Medicaid program payouts are overestimated by 11 percent and unassigned beneficiary liability is underestimated by 10.2 percent. Assigned beneficiary liability is overestimated by 2.8 percent. No real difference is evidenced between the two simulation methodologies for Medicare assigned cases (1.2 percent) and for the Medicaid program payouts (.4 percent). For unassigned cases, beneficiary liabilities are significantly higher (5.9 percent) under the statewide system.

Like the Office Follow-up Visit prevailing charge and reasonable charge, the Hospital Follow-up Visit reflects the urban-rural continuum represented in the five-locality system in terms of the magnitude of the prevailing and reasonable charges calculated for the simulation.

In sum, both the Office Follow-up Visit and Hospital Follow-up Visit indicate no impact of significance on program payouts from change to a statewide methodology. Some impact is evidenced on beneficiary liability for unassigned cases. Thus there appears to be little or no reason to assume that conversion to the statewide methodology will increase program payouts to any significant degree. However some significant increase in unassigned beneficiary liability, 5.9 percent for Hospital Follow-up Visit and 3.1 percent for Office Follow-up Visit, is observed for the statewide methodology.

TABLE VIII

Special Report: Hospital Follow-up Visit in Dollars
Fee Screen Year 1979

Locality	Prevailing Charge*	Weighted Average Reasonable Charge	MEDICARE Assigned Program Payout	MEDICARE Assigned Beneficiary Liability	MEDICARE Unassigned Program Payout	MEDICARE Unassigned Beneficiary Liability	MEDICAID Program Payout	CROSSOVERS Medicare	CROSSOVERS Medicaid
AREA 1									
Multilocality	13.00	10.85	1,310,056	327,514	1,533,573	686,866	153,886	409,081	102,270
Statewide		9.88	1,203,268	300,817	1,386,343	834,093	139,341	360,998	90,249
AREA 2									
Multilocality	10.00	8.00	720,008	180,002	775,136	365,923	78,794	132,868	33,217
Statewide		8.00	720,008	180,002	775,136	365,923	78,794	132,868	33,217
AREA 3									
Multilocality	10.00	6.34	495,444	123,861	168,170	82,538	60,544	190,521	47,630
Statewide		6.49	506,620	126,655	172,665	78,052	61,147	199,267	49,817
AREA 4									
Multilocality	10.00	6.31	880,312	220,078	625,043	384,659	112,988	367,595	91,899
Statewide		6.62	921,184	230,296	659,389	350,312	124,314	386,830	96,707
AREA 5									
Multilocality	10.00	6.34	976,116	244,029	549,656	275,551	100,648	474,999	118,750
Statewide		6.36	978,380	244,595	552,420	272,781	101,182	494,958	123,739
ALL									
Multilocality		7.78	4,381,964	1,095,491	3,651,561	1,795,546	506,865	1,575,070	393,767
Statewide	10.00	7.62	4,329,484	1,082,371	3,545,936	1,901,169	504,782	1,574,930	393,733
Actual History Tapes	Total Payout $7,541,153			Total Assigned Liability $1,052,859		Total Unassigned Liability $2,116,837	Total Payout $454,778	Total Payout $1,438,740	Total Payout $353,685

*Prevailing charges are localitywide.

I. Type of Charge Selected as Reasonable Charge

Tables IX-A (Medicare), IX-B (Medicaid), and IX-C (Medicare-Medicaid interface) present the proportion of selections for each of the three charges--the submitted, prevailing and customary--as the reasonable charge.

For Medicare and crossover claims the prevailing charge is selected as reasonable charge (i.e., amount of payment for a service) slightly more often, overall, under the statewide simulation than under the multi-locality simulation (15.4 percent vs. 13.9 percent and 30.3 percent vs. 28.3 percent, respectively). The difference between the two simulations is negligible for the Medicaid program (Table IX-B) in terms of proportion of the prevailing charges selected.

The Medicare pattern in relation to the prevailing charge is contributed to greatly by the situation in Locality 1, where the prevailing charge is selected considerably more frequently under the statewide simulation than under the multilocality simulation (25.1 percent vs. 16.3 percent). Medicaid shows a simular distribution, with 25.7 percent prevailing selections in Locality 1 under the statewide simulation, versus 15.3 percent for the multilocality simulation. Comparable selections for crossover claims are 47.1 vs. 34.6 percent. The difference between the two simulations in Locality 1 reflects the fact that the Locality 1 prevailing charges will be depressed by lower customary and the submitted charges from rural localities.

By contrast, in Locality 5 (the most rural area) under the statewide simulation, prevailing charges are selected as the method of payment in only 5.8 percent of cases, vs. 9.1 percent of cases under the multilocality simulation for the Medicare program.

Table IX-A also shows that, for Medicare, the submitted charge is the charge most often chosen as the basis for payment (under either simulation) for all localities except Locality 1, where the customary charge is chosen slightly more often than the submitted charge. This probably indicates a higher inflation rate for claims for medical services in Locality 1 than in other, less urban, localities. Therefore, the customary charge would be more frequently lower than the submitted charge in Locality 1 under either simulation.

Table IX-B shows a different pattern for Medicaid reasonable charges. In all other localities, the customary charge is chosen proportionately more often than it is chosen in Locality 1. As for Medicare, the submitted charge is chosen more frequently than the customary or prevailing charge; however under the Medicaid program, the customary charge is more likely to

be chosen than under the Medicare program under either simulation, indicating that the customary charges are generally lower for the Medicaid program than for the Medicare program. This is a function of the procedure for calculating customary charges for the Medicaid program, which requires that the customaries be at least as low as their counterparts under the Medicare program.

Table IX-C for crossover claims shows the customary charge is selected much more frequently than either the submitted charge or the prevailing charge. This may reflect irregularities in the data rather than actual practice in Arkansas. These figures indicate one of two possibilities: 1) the submitted charge has not been recorded on most crossover records, or 2) the submitted charges on crossover records are high, compared to the general population of charges for all Medicare and Medicaid claims. This latter explanation, judging from a cursory examination of a small sample of crossover records, appears to be the most likely one. This is an irregularity in data entry procedures, rather than a reflection of real charging patterns.

TABLE IX-A

Charge Selected as Method of Payments Medicare Fee Screen Year 1979

LOCATION	PRICING METHOD	SUBMITTED CHARGE		CUSTOMARY		PREVAILING		TOTAL CLAIMS	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
AREA 1	MULTIPLE AREA	302672	38.7	327361	41.8	152421	19.5	782454	100.0
	STATEWIDE	254847	32.6	285898	36.5	241709	30.9	782454	100.0
AREA 2	MULTIPLE AREA	183260	47.4	119830	31.0	83388	21.6	386478	100.0
	STATEWIDE	194987	50.5	121531	31.4	69960	18.1	386478	100.0
AREA 3	MULTIPLE AREA	106728	46.1	84109	36.3	40875	17.6	231712	100.0
	STATEWIDE	116966	50.5	83640	36.1	31106	13.4	231712	100.0
AREA 4	MULTIPLE AREA	196052	44.7	151210	34.5	90919	20.7	438181	100.0
	STATEWIDE	205521	46.9	153936	35.1	78724	18.0	438181	100.0
AREA 5	MULTIPLE AREA	228981	50.4	175399	38.6	50229	11.0	454609	100.0
	STATEWIDE	231926	51.0	175647	38.6	47036	10.3	454609	100.0
OVERALL	MULTIPLE AREA	1017693	44.4	857909	37.4	417832	18.2	2293434	100.0
	STATEWIDE	1004247	43.8	820652	35.8	468535	20.4	2293434	100.0

TABLE IX-B

Charge Selected as Method of Payments Medicaid Fee Screen Year 1979

LOCATION	PRICING METHOD	SUBMITTED CHARGE		CUSTOMARY		PREVAILING		TOTAL CLAIMS	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
AREA 1	MULTIPLE AREA	33795	45.3	29365	39.4	11416	15.3	74576	100.0
	STATEWIDE	28292	37.9	27150	36.4	19134	25.7	74576	100.0
AREA 2	MULTIPLE AREA	28509	43.7	27057	41.5	9647	14.8	65213	100.0
	STATEWIDE	29143	44.7	27417	42.0	8653	13.3	65213	100.0
AREA 3	MULTIPLE AREA	38848	46.0	33748	40.0	11792	14.0	84388	100.0
	STATEWIDE	40206	47.6	34155	40.5	10027	11.9	84388	100.0
AREA 4	MULTIPLE AREA	41528	40.3	43808	42.5	17778	17.2	103114	100.0
	STATEWIDE	41922	40.7	44647	43.3	16545	16.0	103114	100.0
AREA 5	MULTIPLE AREA	58898	47.6	51486	41.6	13378	10.8	123762	100.0
	STATEWIDE	59367	48.0	51615	41.7	12780	10.3	123762	100.0
OVERALL	MULTIPLE AREA	201578	44.7	185464	41.1	64011	14.2	451053	100.0
	STATEWIDE	198930	44.1	184984	41.0	67139	14.9	451053	100.0

TABLE IX-C

Charge Selected as Method of Payment: Crossovers Fee Screen Year 1979

LOCATION	PRICING METHOD	SUBMITTED CHARGE NUMBER	SUBMITTED CHARGE PERCENT	CUSTOMARY NUMBER	CUSTOMARY PERCENT	PREVAILING NUMBER	PREVAILING PERCENT	TOTAL CLAIMS NUMBER	TOTAL CLAIMS PERCENT
AREA 1	MULTIPLE AREA	6826	11.3	32613	54.1	20837	34.6	60276	100.0
	STATEWIDE	4557	7.6	27329	45.3	28390	47.1	60276	100.0
AREA 2	MULTIPLE AREA	4773	13.4	22034	61.8	8849	24.8	35656	100.0
	STATEWIDE	3600	10.1	22259	62.4	9797	27.5	35656	100.0
AREA 3	MULTIPLE AREA	6495	10.0	31944	49.4	26242	40.6	64681	100.0
	STATEWIDE	5814	9.0	32132	49.7	26735	41.3	64681	100.0
AREA 4	MULTIPLE AREA	9404	9.1	68460	65.9	26016	25.0	103880	100.0
	STATEWIDE	9166	8.8	68570	66.0	26144	25.2	103880	100.0
AREA 5	MULTIPLE AREA	21305	14.3	92464	62.2	34912	23.5	148681	100.0
	STATEWIDE	21267	14.3	93218	62.7	34196	23.0	148681	100.0
OVERALL	MULTIPLE AREA	48803	11.8	247515	59.9	116856	28.3	413174	100.0
	STATEWIDE	44404	10.7	243508	58.9	125262	30.3	413174	100.0

J. Assignment Rates and Frequencies for FSY 1979

Analysis of the figures on assignment rates will be part of the trend analysis. However, a few observations on the data presented in Tables X-A, -B,-C,-D are in order. These data reflect the actual figures on physician assignment under Medicare in Arkansas for FSY 1979.

It is interesting to note that assignment rates in Localities 1 and 2 (the most urban localities) are below 50 percent for all quarters, whereas assignment rates are above 50 percent for all quarters in the remaining three localities. In the overall picture, assignment rates are lower in the Medical Specialties and Surgical Specialties categories than in the General Practice and Other categories, and this holds for each quarter of the year. However, this overall picture is mixed when each locality and payment group is considered individually. Thus, for example, while the Medical Specialties category is lowest in assignment frequency in all four quarters of the year in Locality 5, and is lowest in three of the four quarters in Locality 3, it is highest in assignment frequency in three of the four quarters in Locality 4.

In the overall picture, slightly over half of all claims received are assigned. Surgical Specialties are least frequently assigned.

These figures will be discussed fully in the two-year comparative analysis.

TABLE X-A

Assignment Frequencies for Quarter 3 of Year 1978

		- PAYMENT GROUPS -									
LOCATION	PAYMENT STATUS	MEDICAL SPECIALTIES	Assignment Rate*	GENERAL PRACTICE	Assignment Rate*	SURGICAL SPECIALTIES	Assignment Rate*	OTHER PHYSICIANS	Assignment Rate*	TOTAL, ALL PHYSICIANS	Assignment Rate*
AREA 1	ASSIGNED	22445	(36.1%)	12229	(35.5%)	11352	(37.1%)	44222	(63.4%)	90248	(45.8%)
	UNASSIGNED	39685		22257		19245		25575		106762	
AREA 2	ASSIGNED	14493	(42.9%)	17115	(50.3%)	8718	(32.5%)	95	(8.5%)	40421	(42.2%)
	UNASSIGNED	19293		16936		18073		1024		55326	
AREA 3	ASSIGNED	5148	(50.3%)	27124	(70.0%)	4860	(61.4%)	65	(66.3%)	37197	(65.3%)
	UNASSIGNED	5073		11617		3058		33		19781	
AREA 4	ASSIGNED	11311	(60.5%)	41773	(55.7%)	6440	(53.0%)	52	(42.3%)	59576	(56.2%)
	UNASSIGNED	7399		33167		5703		71		46340	
AREA 5	ASSIGNED	169	(26.5%)	65084	(60.9%)	1889	(51.0%)	170	(42.7%)	67312	(60.3%)
	UNASSIGNED	468		41723		1817		228		44236	
OVERALL	ASSIGNED	53566	(42.7%)	163325	(56.5%)	33259	(41.0%)	44604	(62.4%)	294754	(52.0%)
	UNASSIGNED	71918		125700		47896		26931		272445	

*Assignment rate = assigned ÷ assigned + unassigned

TABLE X-B

Assignment Frequencies for Quarter 4 of Year 1978

		- PAYMENT GROUPS -									
LOCATION	PAYMENT STATUS	MEDICAL SPECIALTIES	Assignment Rate*	GENERAL PRACTICE	Assignment Rate*	SURGICAL SPECIALTIES	Assignment Rate*	OTHER PHYSICIANS	Assignment Rate*	TOTAL, ALL PHYSICIANS	Assignment Rate*
AREA 1	ASSIGNED	24732	(38.0%)	13110	(36.9%)	12470	(37.3%)	44859	(66.6%)	95171	(47.2%)
	UNASSIGNED	40409		22436		20995		22525		106365	
AREA 2	ASSIGNED	14546	(42.5%)	14911	(43.9%)	8324	(31.2%)	171	(12.6%)	37952	(39.4%)
	UNASSIGNED	19691		19056		18326		1188		58261	
AREA 3	ASSIGNED	4621	(51.5%)	27453	(68.7%)	6693	(69.0%)	65	(73.0%)	38832	(66.1%)
	UNASSIGNED	4357		12483		3009		24		19873	
AREA 4	ASSIGNED	11841	(61.0%)	37679	(50.8%)	7060	(51.9%)	96	(45.7%)	56676	(52.7%)
	UNASSIGNED	7569		36552		6538		114		50773	
AREA 5	ASSIGNED	179	(31.3%)	64587	(60.3%)	1210	(44.4%)	357	(41.8%)	66333	(59.6%)
	UNASSIGNED	392		42493		1514		498		44897	
OVERALL	ASSIGNED	55919	(43.6%)	157740	(54.3%)	35757	(41.5%)	45548	(65.2%)	294964	(51.3%)
	UNASSIGNED	72418		133020		50382		24349		280169	

*Assignment rate = assigned ÷ assigned + unassigned

TABLE X-C

Assignment Frequencies for Quarter 1 of Year 1979

		- PAYMENT GROUPS -									
LOCATION	PAYMENT STATUS	MEDICAL SPECIALTIES	Assignment Rate*	GENERAL PRACTICE	Assignment Rate*	SURGICAL SPECIALTIES	Assignment Rate*	OTHER PHYSICIANS	Assignment Rate*	TOTAL, ALL PHYSICIANS	Assignment Rate*
AREA 1	ASSIGNED	24631	(38.5%)	13137	(38.8%)	10863	(36.6%)	41904	(67.4%)	90535	(47.8%)
	UNASSIGNED	39269		20678		18807		20260		99014	
AREA 2	ASSIGNED	15400	(44.6%)	14920	(45.5%)	8349	(32.1%)	184	(12.6%)	38853	(41.0%)
	UNASSIGNED	19132		17845		17694		1273		55944	
AREA 3	ASSIGNED	4957	(53.0%)	29186	(72.9%)	5590	(67.3%)	110	(48.7%)	39843	(68.8%)
	UNASSIGNED	4397		10869		2716		116		18098	
AREA 4	ASSIGNED	12152	(61.2%)	44744	(56.0%)	6393	(51.3%)	81	(34.9%)	63370	(56.7%)
	UNASSIGNED	7689		35143		6069		151		49052	
AREA 5	ASSIGNED	171	(32.0%)	70355	(62.3%)	2119	(53.8%)	349	(33.1%)	72994	(61.7%)
	UNASSIGNED	363		42486		1820		705		45374	
OVERALL	ASSIGNED	57311	(44.7%)	172342	(57.6%)	33314	(41.4%)	42628	(65.4%)	305595	(53.3%)
	UNASSIGNED	70850		127021		47106		22505		267482	

*Assignment rate = assigned ÷ assigned + unassigned

TABLE X-D

Assignment Frequencies for Quarter 2 of Year 1979

		- PAYMENT GROUPS -									
CATION	PAYMENT STATUS	MEDICAL SPECIALTIES	Assignment Rate*	GENERAL PRACTICE	Assignment Rate*	SURGICAL SPECIALTIES	Assignment Rate*	OTHER PHYSICIANS	Assignment Rate*	TOTAL, ALL PHYSICIANS	Assignment Rate*
REA 1	ASSIGNED	26657	(38.8%)	12272	(34.7%)	10758	(33.0%)	36795	(63.6%)	86482	(44.5%)
	UNASSIGNED	41975		23065		21811		21026		107877	
REA 2	ASSIGNED	15847	(43.0%)	15098	(43.8%)	7874	(29.6%)	173	(9.6%)	38992	(39.1%)
	UNASSIGNED	21016		19353		18740		1620		60729	
REA 3	ASSIGNED	5425	(55.0%)	26969	(68.9%)	5928	(66.3%)	111	(84.7%)	38433	(66.2%)
	UNASSIGNED	4443		12183		3009		20		19655	
REA 4	ASSIGNED	11775	(56.2%)	40487	(53.0%)	7093	(50.6%)	735	(68.9%)	60090	(53.5%)
	UNASSIGNED	9178		35868		6927		331		52304	
REA 5	ASSIGNED	174	(27.1%)	65747	(60.7%)	1714	(53.4%)	367	(29.8%)	68002	(59.9%)
	UNASSIGNED	468		42635		1493		865		45461	
VERALL	ASSIGNED	59878	(43.7%)	160573	(54.7%)	33367	(39.1%)	38181	(61.5%)	291999	(50.5%)
	UNASSIGNED	77080		133104		51980		23862		286026	

*Assignment rate = assigned ÷ assigned + unassigned

K. Distribution of Physicians

Tables XI-A and XI-B show population estimates for the State of Arkansas and the distribution of active physicians throughout the State. These statistics were obtained from Arkansas Health Manpower Statistics for Physicians (1978 and 1980).

Population and numbers of physicians by locality, and estimates of population/physician ratios by locality, were obtained by utilizing figures supplied for each county and aggregating them into the five localities.

Several observations are relevant to the current research on availability of medical services in Arkansas:

1. Although all areas have experienced a decrease in their population/physician ratio, the largest absolute increase in number of physicians--by far--has been in Locality 1, the most urban locality, with 199 physicians added. This area also had the largest number of physicians at the beginning of the study period. However, as a percentage increase, the gain in Locality 1 is slightly below the statewide rate of increase.

2. All five localities experienced a decrease in the average potential caseload per physician, measured by the population/physician ratio. The greatest gains in improving this ratio were experienced in the most rural localities, particularly in Locality 5 (where the ratio was reduced by 785 potential patients per physician). This change also reflects a large population decline in Locality 5, occurring along with an increase in the number of active physicians. In spite of this improvement, the potential caseload in Locality 5 was still more than twice as great as the statewide figure, and was substantially higher than in any of the other four localities.

3. The greatest proportional increase in number of physicians was experienced in Locality 4, one of the two most rural localities, with close to 30 percent more active physicians appearing there in 1980 than in 1978.

Table XI-C plots physician movements in and out of the five localities. It reveals little change in the status quo as far as relocation of physicians is concerned. Figures above the diagonal represent numbers of physicians relocating in localities less rural than they left, and those below the diagonal indicate numbers relocating to localities on the more rural end of the rural-urban continuum. As can be observed in the Table, very few physicians relocated over the period in question--22 in all. Of these, 8 relocated in the same locality, 8 relocated in a more rural locality, and 6 relocated in a more urban locality. Very little can be concluded from these figures. There is no indication against the argument that the change in fee screen computation will encourage physicians to practice in rural areas. However, given the overall improvement in population/physician ratios, the argument appears to have little merit. In any case, physician movement appears to be minimal.

TABLE XI-A

Arkansas Population Estimates by Locality, 1978 and 1980*

	1978	1980	CHANGE	
			DIFFERENCE	PERCENT
Locality 1	422,436	434,242	11,806	2.8
Locality 2	390,594	403,267	12,673	3.2
Locality 3	257,689	272,462	14,773	5.7
Locality 4	453,831	465,729	11,898	2.6
Locality 5	691,703	666,917	- 24,786	- 3.4
Statewide	2,216,253	2,242,617	26,364	1.2

*Source: Arkansas Health Manpower Statistics for Physicians, 1978 and 1980.

TABLE XI-B

Change in Numbers of Doctors and Population/Active Physician in Arkansas: 1978 and 1980*

	NUMBER OF MDs		CHANGE IN NUMBER OF MDs	PERCENT INCREASE	NUMBER OF PERSONS PER MD		REDUCTION IN PERSONS PER MD
	1978	1980			1978	1980	
Locality 1	966	1,165	+ 199	20.6	437	373	- 64
Locality 2	406	488	+ 82	20.2	962	826	- 136
Locality 3	134	1,671	+ 33	24.6	1,923	1,632	_ 291
Locality 4	251	326	+ 75	29.9	1,808	1,429	- 379
Locality 5	234	272	+ 36	15.3	2,831	2,046	- 775
Statewide	1,991	2,418	+ 427	21.4	1,113	927	- 186

*Source: Arkansas Health Manpower Statistics for Physicians, 1978 and 1980.

TABLE XI-C

Physician Movement: October 1977 - March 1979

AREA FROM:	1	2	3	4	5
AREA TO:					
1	1	0	0	1	0
2	2	1	0	2	0
3	0	0	1	1	2
4	2	1	0	4	0
5	2	0	0	1	1

L. Summary of First Year Data

A few patterns have appeared in the data presented which are relevant to the evaluation of the conversion from a multilocality to single-locality system for calculating prevailing charges in Arkansas.

For Medicare total payouts (Tables I-A,-B,-C,-D) the overall figures reflect conditions in Locality 1. This is a result of the preponderance of medical services billed in that locality. As the most urban locality in Arkanas and the one with the highest proportion of specialists, Locality 1 exhibits a pattern for payouts, assignment rates, beneficiary liability and basis for reasonable charge which differs, in many instances, from the rest of the localities in the State.

The simulation indicates that, under the statewide system, total program payouts for the Medicare system are slightly--but insignificantly--reduced.

For Medicaid payouts, Tables II-A,-B,-C,-D, utilizing the statewide methodology reduces the total payouts by about 3 percent, which is significantly lower than with the multilocality simulation.

Beneficiary liabilities for assigned claims presented in Tables III-A, -B, -C,-D exhibit the same patterns as total Medicare payout figures--a slight but insignificant decrease in liability under the statewide system.

Tables IV-A,-B,-C,-D for beneficiary liabilities for unassigned claims indicate an increase in beneficiary liability of 2.3 percent utilizing the statewide simulation. Summing the two figures for beneficiary liability, however, indicates a net increase in beneficiary liability under the statewide methodology of about 1 percent, which is substantively insignificant.

Payouts for Medicare and Medicaid crossover claims (Tables V-A,-B,-C,-D, and VI-A,-B,-C,-D, respectively) indicate a substantial reduction in payout under the statewide methodology--about 4 percent.

The two intensively analyzed procedure codes--Office Follow-up Visit and Hospital Follow-up Visit, are represented in Table VII and Table VIII, respectively. For both procedure codes, there was no significant difference in total payouts for crossover claims, Medicare assigned claims, and Medicaid payouts utilizing the two methodologies.

There is, however, a significant increase in the unassigned beneficiary liability for both procedure codes utilizing the statewide methodology.

Tables IX-A (Medicare), IX-B (Medicaid), and IX-C (Medicare-Medicaid interface) indicate different patterns in which of the three charges, the submitted, prevailing or customary, is selected as the reasonable charge. For both Medicare and Medicaid programs, there is a large difference between proportion of prevailing charge selections under the multilocality versus the statewide system for Locality 1, the most urban locality, with prevailing charges selected much more frequently under the statewide methodology. This, of course, reflects the decrease in the prevailing charge utilizing statewide, rather than locality, data for the urban areas. The two programs differ in that the customary charge is much more likely to be selected as the reasonable charge for the Medicaid program than for the Medicare program, probably reflecting a lower customary charge for the Medicaid program.

Figures on assignment rates for the first fee screen year have been presented, in Table X, with the observation that assignment rates in the three more rural localities exceed 50 percent, while those in Localities 1 and 2, the more urban localities, fall below 50 percent. Overall, slightly over half of all claims are assigned for FSY 1979.

Tables XI-A, XI-B, and XI-C present data on Arkansas physicians. Table XI-A presents population and population change from 1978 to 1980 within localities. Table XI-B gives numbers of active physicians in Arkansas, for years 1978 and 1980 and changes in population/physician ratio. These two tables indicate a general increase in number of physicians as a proportion of the total population in all localities.

Table XI-C shows relocation of physicians who participated in the Medicare program from October 1977 to March 1979. This last table shows that very few relocated at all, and gives no support to the contention that change in the prevailing charge methodology to a statewide system will encourage physicians to relocate in rural areas.

In sum, the data presented above indicate no substantive adverse impact on program payouts, beneficiary liability, or availability of medical services in Arkansas as a result of the change from a multilocality to a one-locality system. However, there is no indication of any substantial benefit, in terms of the availability of medical services deriving from the change, either. Subsequent reports will evaluate trends in payouts, liabilities, and assignment rates which may result from the change in the locality system in Arkansas.

APPENDIX I

Medical Specialty Groups

NUMERIC CODES ASSIGNED FOR CATEGORIES FOR ONE LOCALE CONVERSION

III. Field of Practice Categories

Category	Inclusive Specialty
1. Medical Specialties	03 - Allergy 06 - Cardiovascular Diseases 07 - Dermatology 10 - Gastroenterology 11 - Internal Medicine 13 - Neurology 25 - Physical Medicine 26 - Psychiatry 29 - Pulmonary Disease 39 - Nephrology 37 - Pediatrics
2. General Practice	01 - General Practice 08 - Family Practice
3. Surgical Specialties	02 - General Surgery 04 - Otology 14 - Neurological Surgery 16 - Obstetrics - Gynecology 18 - Opthalmology 19 - Oral Surgery 20 - Orthopedic Surgery 24 - Plastic Surgery 28 - Proctology 33 - Thoracic Surgery 34 - Urology
4. Podiatry	48 - Podiatry
6. Osteopathy	12 - Manipulative Therapy 23 - Vascular Surgery 32 - Radiation Therapy

49	Miscellaneous
05	Anesthesiology
22	Pathology
30	Radiology
35	Chiropractors
59	Ambulance Services
51-58, 87	DME and Prosthesis (Optometry - 58)
62	Psychology
64	Audiology
65	Physical Therapy
69	Independent Lab
70	Multi-specialty Clinics
99	Unknown

APPENDIX II

Procedure Codes

MEMORANDUM

To: Designated Recipients

From: David Selby
Research Associate, Planning & Human Systems, Inc.

Date: May 12, 1981

Subject: List of Medical Procedure Codes to be Utilized in the Arkansas Statewide Locality Evaluation Project, HCFA Contract No. HCFA-500-79-0036

The accompanying list of medical procedure codes (Exhibit 2) has been selected for utilization in the subject study.

Inclusions and omissions require discussion, which constitutes the remainder of this memorandum. Exhibit 1 gives a breakout of the numbers of codes to be utilized in various ways, as indicated there and in the list (columns 6-9 itself.

Sources

Three documents constituted the sources of these selections. They were:

1. An internal memorandum from Sharon Allen to Bob Shoptaw, of Arkansas Blue Cross/Blue Shield, dated May 8, 1979, concerning the "One Locality Demonstration Project." This memorandum, and accompanying memoranda to Ms. Allen taken as a single source, is subsequently referred to as "Allen-Shoptaw."

2. A computer listing, supplied by ABCBS, headed "...a list of the most used procedure codes for 1977. The data was extracted from the statewide/no specialty level of prevailing fees for the 1978 PDS update...." This listing is said to reflect combined experience for Medicare and Blue Shield claims in 1977. Inclusion of non-Medicare procedures, such as obstetrical care and related procedures, supports this.

   Information from this list underlies procedures included in Allen-Shoptaw.

3. A computer listing, supplied by the Arkansas DSS, headed "CPT Frequency Report--Top 200 Procedures 1/79-12/79," and produced by MMIS program HCUP54.

All Sources provide both procedure codes and volume data, including frequencies and selected dollar values.

Selection Criteria

The formally established criteria for inclusion of a code in the subject study were: (a) that it occur at least 600 times in one of the source listings, and (b) that the annual dollar value of payout equal or exceed $30,000.

An additional criterion for Medicaid procedures is implied by the purpose of the study, in which Medicaid data are included to assess the impact of the Medicare locality-change upon Medicaid payments. Only those Medicaid procedures which are also Medicare procedures have been included. This exclusion causes the omission of all obstetrical and related codes from the list, despite their acknowledged high-volume status under Medicaid. Certain other codes with an age limitation (such as "under 12") below that of typical Medicare eligibility have also been excluded on this ground.

Two codes for office eye examinations are included, despite Medicare's exclusion of visual acuity care. It is not possible to determine from these codes whether the condition under examination was visual acuity or any of several other possible eye diseases or malfunctions for which treatment is covered by Medicare. The appearance of eye surgery codes among the Medicare high-volume codes supports inclusion of the two eye examination codes.

Finally, analytic and practical considerations constitute additional criteria for inclusion or exclusion of some candidate codes. A discussion of such considerations appears in the Notes appended to Exhibit 2. In general, some candidate codes were excluded because of conflicting information on CPT-CRVS cross-referencing, because pricing is performed manually or in other ways not susceptible to straightforward computer processing, or per-unit prices were adjudged extremely high or low.

Cross-Reference Sources

CPT/CRVS cross-referencing was done on the basis of entries in three sources used in Arkansas. These included:

1. A desk manual prepared and distributed to Medicare providers by Blue Cross/Blue Shield of Arkansas, the Medicare carrier for the State. This list of frequently used procedure codes provides the four-digit CRVS code equivalents prescribed for use by providers, who are said to use CPT in most billing. A January 1980 edition was used, supplemented by the October 1978 edition.

2. A computer listing, dated 4/25/80 and produced by Medicaid MMIS program HFRR04P, of CPT/CRVS pairs (and other information) as matched for purposes of pricing CPT-coded Medicaid claims, where CRVS-coded Medicare fee screens are considered.

3. A computer listing, dated 4/15/80 and produced by Arkansas Blue Shield's program V45810-A, of CRVS to CPT cross-references. Of the three, only this list is ordered by CRVS code; it gives those CPT codes cross-referenced to each CRVS code for computation of fee screens.

In addition, the AMA's official Physician's Current Procedural Terminology, 4th Edition was used as a supplemental reference on procedure nomenclature and the status of CPT codes.

It should be noted that these cross-reference sources were not always in agreement, a situation which caused deletion of some candidate procedures--notably several high-volume psychotherapy codes--from the list of those to be utilized in the study. Further comments on this matter appear in the appended Notes to the list.

Analytical Uses of Codes

The project anticipates three related analytic reports, two covering single years of experience in Arkansas, the third a consolidated report covering both studied years, to include an analysis of comparative pricing and payment data over the period.

Owing to increased refinement of the CPT code scheme, the number of CPT codes expanded between the third and fourth editions of the official CPT classification. Some codes used in CPT3 were deleted and (generally) replaced by multiple new codes. For example, CPT3's 80013 was deleted and replaced by CPT4's 80016, 80018, and 80019. As shown on the last page of Exhibit 2, all of these are cross-referenced to CRVS 5-8015.

For the single-year reports, all high-volume CPT codes in use during the subject year will be incorporated in the data. Although this creates noncomparability in the databases used for the separate years, it has the advantage of being maximally inclusive of high-volume procedures for each year.

Codes Not Priced

Not all codes listed in Exhibit 2 are to be priced, as shown in Exhibit 1. Some CPT codes are listed only to provide description of the procedures cross-referenced to high-volume CRVS codes. Others, however, are included for fee screen computation only, which may require explanation.

In Arkansas, Medicaid allowed payments are determined in a variety of ways, only one of which concerns us (owing to the analytic decisions noted above and in the appendix to Exhibit 2). The method under study involves comparison of the Medicaid provider's submitted charge with appropriate "fee screens," which include:

a. the provider's customary charge as determined from Medicaid claims history,

b. the provider's non-clinic customary charge as determined from Medicare claims history, and

c. the Medicare prevailing charge as determined from Medicare claims history.

With certain exceptions, all CPT codes cross-referenced to a given CRVS code are included in the data used for computations of Medicare customary and prevailing charges. In order to compute fee screens for certain procedures which are high-volume items only in Medicaid, we must extract those CRVS codes (from Medicare data) needed, even though they are not high-volume Medicare items. As Exhibit 1 shows, there are 10 such CRVS codes. No comparable use of Medicaid data exists for pricing of Medicare high-volume items, since Medicare pricing does not depend on Medicaid screens.

The list of Medicaid CPT codes which are to be profiled (but not priced) is longer, including 43 codes. These are required because Medicaid computes its customaries in terms of CRVS codes, rather than for individual CPT codes--even though Medicaid providers bill using CPT.[1] Consequently, we must extract data for all codes which Arkansas Medicaid utilizes in computing a CRVS-coded customary.

For example, though only CPT 90600 (limited consultation, CRVS 3-9027) is a reported high-volume code in Medicaid and therefore to be priced, its sister-code 90605 must be extracted for the sole purpose of computing a fee screen for CRVS 3-9027, the cross-reference for which the applicable Medicaid customary will be computed.

CRVS 2-0171 provides the most extreme example of this situation, and is discussed separately in the appended Notes for Exhibit 2.

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[1] Medicaid customaries are computed on CRVS cross-reference codes, rather than individual CPT codes, in order to allow use of the automated pricing system, according to an Arthur Anderson Company report on Medicaid coding in Arkansas. Use of this practice has been confirmed by Medicaid personnel. In fact, for procedures not covered by Medicare, Arkansas Medicaid creates "dummy" CRVS cross-references as needed to comply with automated system data requirements.

"Duplicated" Procedures

In the diagnostic radiology portion of the list (CRVS prefix 4), some procedures are listed twice. In these cases, the list distinguishes between billings for the total procedure and those for the professional component alone. In Arkansas, the first digit of the base 4-digit CRVS code is used to differentiate among bills for the total procedure (usually leading 0), the technical component alone (7), and the professional component alone (9). Thus, CRVS code 4-0101 designates the total procedure and 4-9101 the professional component for a two-view X-ray of the chest.

Medicaid accomplishes recording of this distinction by including a special procedure-modifier field in its claim record, where a "P" is entered for the professional component and the field left blank for the total procedure. (Arkansas Medicaid does not pay for the technical component alone.)

In some instances, only one of the paired codes appears in the list (i.e., only the total or only the professional component) because only those codes appeared in Medicare lists of high-volume procedure codes. For Medicaid, where lists included only the basic CPT number, it is not possible to determine directly whether the professional or total code, or both, is responsible for high volumes. Therefore, for high-volume radiology procedures obtained from Medicaid lists both CRVS codes will be studied.

The same coding scheme applies to laboratory and pathology procedures, although no codes for professional component alone are included in our list (see discussion in appendix Notes).

Summary

As suggested by the foregoing brief comments, the list of medical procedure codes shown in Exhibit 2 has been compiled on the basis of not only the formal criteria for inclusion but also various considerations about the use of these codes for payment of claims in the Medicare and Medicaid programs in Arkansas. There are additional complications which will be discussed in the methods sections of the report. The list in Exhibit 2 represents the best compromise among competing ideal and feasible criteria for inclusion of codes in the study.

EXHIBIT 1

DISTRIBUTION OF LISTED MEDICAL PROCEDURE CODES

	Total	Profiled	Priced	Neither[1]
Medicare (CRVS)	96	96	85	0
Medicaid (CPT) All	161	118	76	43
Status Group[2]				
7	96	70	62	26
4	46	35	9	11
3	14	11	5	3
0	5	2	0	3

---

[1] Some Medicaid CPT codes merely accompany Medicare high-volume codes to provide descriptions of included procedures. They are neither Medicaid high-volume codes nor Medicaid codes needed for fee-screen computation only.

[2] "Status group" in the list (see column 5) indicates the CPT status (not Medicaid payment status) of listed CPT codes. Status 7 = codes included under both CPT3 and CPT4 (3+4 = 7); status 4 = codes newly added in CPT4; status 3 = codes in use under CPT3 but deleted from CPT4; status 0 = unofficial codes not included in CPT2, CPT3, or CPT4; these are Arkansas "addendum codes." Status determined by reference to official AMA Manual, Physicians' Current Procedural Terminology, 47th Edition.

EXHIBIT 2

MEDICAL PROCEDURE CODES TO BE UTILIZED IN THE SINGLE-LOCALITY EVALUATION PROJECT

Contents by column:

Columns 1/2: Indication of high-volume source lists on which codes appeared, Column 1 pertains to Medicare CRVS codes, column 2 to Medicaid CPT codes.

Columns 3/4: Cross-referenced CRVS codes and CPT codes, as shown in cross-reference sources. The initial digit for codes in column 3 is the Medicare TOS (type of service) code, where:

1 = Medical
2 = Surgical
3 = Consultation
4 = Diagnostic Radiology, Nuclear Medicine, and Ultrasound
5 = Diagnostic Laboratory and Pathology
6 = Radiation Therapy

Column 5: CPT code status, where "7" indicates continuing usage under both CPT3 and CPT4, "4" indicates codes newly added under CPT4, "3" indicates codes used under CPT3 but deleted under CPT4, and "0" indicates non-official CPT-format codes added in Arkansas.

Columns 6/7: Codes to be used in fee-screen computations. Column 6 pertains to CRVS codes, Column 7 to CPT codes. Blanks indicate non-use.

Columns 8/9: Codes to be priced for analyses. Column 8 pertains to CRVS codes, Column 9 to CPT codes. Blanks indicate non-priced codes.

Column 10: Procedure description, as obtained from (a) ABC/BS Physicians' Cross-reference Manual (Frequently Used Procedure Codes, 1/80), (b) Medicaid cross-reference source dated 4/80, or (c) Physicians' Current Procedural Terminology, 4th Edition. The latter, though "official," was used only as a supplement because Arkansas nomenclature occasionally varies.

PROGRAM SOURCE LIST -CARE ("B")	PROGRAM SOURCE LIST -CAID ("A")	PROCEDURE CODE MEDICARE (CRVS)	PROCEDURE CODE MEDICAID (CPT)	CPT CODE STATUS	STUDY USE -- PROFILE B	STUDY USE -- PROFILE A	STUDY USE -- PRICE B	STUDY USE -- PRICE A	DESCRIPTION
x	x	19001	90000	7	x	x	x	x	Office Visit-New Patient: Brief
x	x	"	90010	7	x	x	x	x	Office Visit-New Patient: Limited
x	x	19002	90015	7	x	x	x	x	Office Visit-New Patient: Intermediate
x	x	"	90020	7	x	x	x	x	Office Visit-New Patient: Comprehensive
x	x	"	90021	3	x	x	x	x	Office Visit-New Patient
x		19004	90031	3	x	x	x		Office Visit
x	x	"	90040	7	x	x	x	x	Office Visit-Estab Patient: Brief
x	x	"	90050	7	x	x	x	x	Office Visit-Estab Patient: Limited
x	x	19006	90060	7	x	x	x	x	Office Visit-Estab Patient: Intermediate
x	x	19007	90070	7	x	x	x	x	Office Visit-Estab Patient: Extended
x		"	90089	3	x	x	x		Office Visit-Eye Examination
x	x	19008	90080	7	x	x	x	x	Office Visit-Estab Patient: Comprehensive
x	x	"	90081	3	x	x	x	x	Office Visit
x	x	19011	90450	7	x	x	x	x	Care Facility Service,Single Patient: Limited
x	x	"	90460	7	x	x	x	x	Care Facility Service,Single Patient: Intermediate
x		19014	90150	7	x		x		Home Visit: Limited Service
x		19020	90540	7	x		x		Emergency Care: Brief
x	x	19021	90200	7	x	x	x	x	Hospital Care,Initial: Brief History & Exam
x	x	"	90215	7	x	x	x	x	Hospital Care,Initial: Intermediate Hist & Exam
x	x	19022	90220	7	x	x	x	x	Hospital Care,Initial: Comprehensive Hist & Exam
x	x	19023	90240	7	x	x	x	x	Hospital Follow-up Visit: Brief
x	x	"	90250	7	x	x	x	x	Hospital Follow-up Visit: Limited
x	x	19025	90260	7	x	x	x	x	Hospital Follow-up Visit: Intermediate
	x	19026	90270	7	x	x		x	Hospital Follow-up Visit: Extended
x		19111	90431	3	x	x	x		Care Facility Service
x	x	"	90440	7	x	x	x	x	Care Facility Service,Multi-patient: Brief
x		"	90455	0	x	x	x		Care Facility Service,Multi-patient: Limited
x		19356	92013	0	x		x		Eye Examination, Without Refraction
x		19529*	97260	7	x		x		Regional Manipulation, One Area

* Type of Service (TOS) prefix "C" designates chiropractor in Arkansas.

PROGRAM SOURCE LIST -CARE ("B")	PROGRAM SOURCE LIST -CAID ("A")	PROCEDURE CODE MEDICARE (CRVS)	PROCEDURE CODE MEDICAID (CPT)	CPT CODE STATUS	STUDY USE -- PROFILE B	STUDY USE -- PROFILE A	STUDY USE -- PRICE B	STUDY USE -- PRICE A	DESCRIPTION
x		20103	10060	7	x	x	x	x	Incision & Drainage of Abcess; Simple
x		"	26010	7	x	x	x		Drainage of Finger Abcess; Simple
x		20171	11100	7	x	x	x	x	Biopsy of Skin Lesion; One Lesion
x		"	11101	7	x	x	x		Biopsy of Skin Lesion; Each Additional Lesion
x		"	11200	7	x	x	x		Removal of Skin Tags; Up to 15
x		"	11201	7	x	x	x		Removal of Skin Tags; Each Additional 10 Lesions
x		"	21550	4	x	x	x	x	Biopsy,Soft Tissue of Neck/Thorax
x		"	22010	4	x	x	x		Biopsy, Soft Tissue of Spine; Superficial
x		"	24065	4	x	x	x		Biopsy Arm/Elbow Soft Tissue; Superficial
x		"	25065	4	x	x	x		Biopsy Forearm/Wrist Soft Tissue; Superficial
x		"	27040	4	x	x	x		Biopsy Pelvis/Hip Joint Soft Tissue; Superficial
x		"	27323	4	x	x	x		Biopsy Thigh/Knee Joint Soft Tissue; Superficial
x		"	27613	4	x	x	x		Biopsy Leg/Ankle Joint Soft Tissue; Superficial
x		"	21555*	4	x	x	x		Excision Benign Tumor Neck/Thorax; Subcutaneous
x		"	22011	4	x	x	x		Biopsy, Soft Tissue of Spine;Deep
x		"	22030	4	x	x	x		Excision, Benign Tumor Spine; Subcutaneous
x		"	24066	4	x	x	x		Biopsy Arm/Elbow Soft Tissue; Deep
x		"	24075	4	x	x	x		Excision, Benign Tumor Arm/Elbow; Subcutaneous
x		"	25066	4	x	x	x		Biopsy Forearm/Wrist Soft Tissue; Deep
x		"	25075	4	x	x	x		Excision, Benign Tumor Forearm/Wrist; Subcutaneous
x		"	26115	4	x	x	x		Excision, Benign Tumor Hand/Fingers; Subcutaneous
x		"	27047	4	x	x	x		Excision, Benign Tumor Pelvis/Hip Joint; Subcutaneous
x		"	27327	4	x	x	x		Excision, Benign Tumor Thigh/Knee Joint; Subcutaneous
x		"	27618	4	x	x	x		Excision, Benign Tumor Leg/Ankle Joint; Subcutaneous
x		"	28043	4	x	x	x		Excision, Benign Tumor Foot; Subcutaneous
x		20173	11420	7	x		x		Removal of Skin Lesion, ex. Tags; Up to 0.5 cm.
x		20176	11421	7	x		x		Removal of Skin Lesion, ex. Tags; 0.5 - 1.0 cm.

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* CPT 21555 and other codes cross-referenced to CRVS 2-0171 below dividing line are substantially higher-priced than those above divider. See comments regarding this set of codes in attached Notes.

PROGRAM URCE LIST		PROCEDURE CODE		CPT CODE STATUS	STUDY USE -- PROFILE		PRICE		DESCRIPTION
ARE B")	-CAID ("A")	MEDICARE (CRVS)	MEDICAID (CPT)		B	A	B	A	
x		20369	13400	0	x		x		First Aid: Complex Repair of Integuementary System
x		20401	17000	7	x		x		Destroy One Lesion; Any Method, Any Location
x		20410	11050*	4	x		x		Curette Benign Skin Lesion; Single Lesion
x		20417	11051*	4	x		x		Curette Benign Skin Lesion; Two to Four Lesions
x		22442**	93547	4	x	x	x	x	Combined Left Heart Catheterization, etc,
x		"	93548	4	x	x	x		Combined Left Heart Catheterization, etc,, and Root Aortograp
x		"	93549	4	x	x	x		Combined Right and Left Heart Catheterization,etc,
x		23128	43235	4	x		x		Upper GI Endoscopy; Diagnosis
	x	23261	44950	7	x	x		x	Excision of Appendix
x		23311	45300	7	x		x		Proctosigmoidoscopy; Diagnostic
x		"	45302	4	x		x		Proctosigmoidoscopy; With Specimen Collection
	x	23515	47600	7	x	x		x	Removal of Gallbladder
	x	23516	47605	7	x	x		x	Removal of Gallbladder, with Cholangiography
	x	23571	49000	7	x	x		x	Exploration of Abdomen
x		23931	52100	7	x		x		Cystourethroscopy; Hospital
x		23947	52000	7	x		x		Cystourethroscopy; Office
x		24031	53600	7	x		x		Dilation of Urethral Stricture,Male; Initial
x		"	53601	7	x		x		Dilation of Urethral Stricture, Male; Subsequent
x		24036	53660	7	x		x		Dilation of Urethra, Female; Initial
x		"	53661	7	x		x		Dilation of Urethra, Female; Subsequent
x		24321	52600	3	x		x		Remove Prostate Thru Urethra
x		"	52601	4	x		x		Prostatectomy, Transurethral Resection; Complete
x		"	52610	3	x		x		Removal of Prostate
x	x	24617	58150	7	x	x	x	x	Total Hysterectomy

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*CPT 11050 is one of eight CPT codes, 11051 one of five codes incorporated in the Medicare fee screen computations for their respective CRVS cross-references. Other codes omitted to save space, given no pricing for Medicaid.

** CRVS 2-2442 fails the frequency criterion by 64 services (@ 536 in 1977), but has a high dollar total owing to high price of procedure. See additional comments on this code in attached Notes.

x		25619	66850	7	x		x		Removal of Lens Material; Microscopic/Phakofrag. Method
	x	25963	69435	7	x	x		x	Create Eardrum Opening, In Surgical Suite; Unilateral
x	x	39027	90600	7	x	x	x	x	Consultant Services: Limited
x		"	90605	4	x	x	x		Consultant Services: Intermediate
x	x	39028	90620	7	x	x	x	x	Consultant Services: Comprehensive
	x	39055	90610	7	x	x		x	Consultant Services: Extensive
x	x	40020	70220-*	7	x	x	x	x	XRAY Exam of Sinuses,Complete; Without Contrast
x	x	40100	71010-	7	x	x	x	x	XRAY Exam of Chest; P.A. View
x	x	40101	71020-	7	x	x	x	x	XRAY Exam of Chest; P.A. and Lateral Views
x	x	40210	72100-	7	x	x	x	x	XRAY Exam of Lower Spine; A.P. and Lateral Views
x		40211	72080-	7	x	x	x		XRAY Exam of Spine; Thoracolumbar, A.P., and Lateral Views
x	x	"	72110-	7	x	x	x	x	XRAY Exam of Lower Spine; Complete, with Oblique Views
x		40217	72170-	7	x		x		XRAY Exam of Pelvis; A.P. View Only
x		40252	73030-	7	x		x		XRAY Exam of Shoulder; Complete, Minimum Two Views
x	x	40256	73110-	7	x	x	x	x	XRAY Exam of Wrist; Complete, Minimum Three Views
x		40257	73130-	7	x		x		XRAY Exam of Hand; Minimum Three Views
x		40300	73510-	7	x		x		XRAY Exam of Hip; Complete, Minimum Two Views
x		40304	73570-	7	x		x		XRAY Exam of Knee; Complete, Minimum Three Views
x	x	40306	73610-	7	x	x	x	x	XRAY Exam of Ankle; Complete, Minimum Three Views
x		"	73616-	4	x	x	x		XRAY Exam of Ankle; Arthrography, Complete Procedure
x	x	40307	73630-	7	x	x	x	x	XRAY Exam of Foot; Complete, Minimum Three Views
x		"	73650-	7	x	x	x		XRAY Exam of Heel; Minimum Two Views
x	x	40358	74240-	7	x	x	x	x	XRAY Exam of Upper GI Tract; Without KUB
x	x	"	74241-	7	x	x	x	x	XRAY Exam of Upper GI Tract; With KUB
x	x	40360	74270-	7	x	x	x	x	Contrast XRAY Exam of Colon; Barium Enema
x	x	40364	74290-	7	x	x	x	x	Contrast XRAY Gallbladder; Oral Contrast
x		"	74291-	7	x	x	x		Contrast XRAY Gallbladder; Add/Rpt/Multi-day Exam
x	x	40371	74400-	7	x	x	x	x	Contrast XRAY Urinary Tract; Intravenous
x	x	49026	70260P*	7	x	x	x	x	XRAY Exam of Skull; Complete, Minimum Four Views

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uffix " - " indicates complete procedure; " P " indicates professional component only. here the Medicare high-volume source list included the professional component code as a eparate item, it is listed separately here. See further comments in attached Notes.

PROGRAM SOURCE LIST -CARE ("B")	PROGRAM SOURCE LIST -CAID ("A")	PROCEDURE CODE MEDICARE (CRVS)	PROCEDURE CODE MEDICAID (CPT)	CPT CODE STATUS	STUDY USE -- PROFILE B	STUDY USE -- PROFILE A	STUDY USE -- PRICE B	STUDY USE -- PRICE A	DESCRIPTION
x	x	49100	71010P*	7	x	x	x	x	XRAY Exam of Chest; P.A. View
x	x	49101	71020P	7	x	x	x	x	XRAY Exam of Chest; P.A. and Lateral Views
x		49206	72052P	7	x		x		XRAY Exam of Neck-Spine;Comp., w/Oblique/Flex-Extens.
x		49211	72080P	7	x	x	x		XRAY Exam of Spine; Thoracolumbar, A.P., and Lateral Views
x	x	"	72110P	7	x	x	x	x	XRAY Exam of Lower Spine; Complete, with Oblique Views
x		49263	78306P	7	x		x		Nuclear Scan of Bones; Whole Body
x		49357	74250P	7	x		x		XRAY Exam of Small Bowel; Including Multiple Serial Films
x	x	49358	74240P	7	x	x	x	x	XRAY Exam Upper GI Tract; Without KUB
x	x	"	74241P	7	x	x	x	x	XRAY Exam Upper GI Tract; With KUB
x	x	49360	74270P	7	x	x	x	x	Contrast XRAY Exam of Colon; Barium Enema
x	x	49364	74290P	7	x	x	x	x	Contrast XRAY Gallbladder; Oral Contrast
x		"	74291P	7	x	x	x		Contrast XRAY Gallbladder; Add/Rpt/Multi-day Exam
x	x	49371	74400P	7	x	x	x	x	Contrast XRAY Urinary Tract; Intravenous
x		49381	74410P	7	x		x		Contrast XRAY Urinary Tract; Infusion, Drip Method
x		49386	74011P	9	x	x	x		Acute Abdominal Series
x	x	"	74020P	7	x	x	x	x	XRAY Exam of Abdomen; Compl., Incl. Decubitis/Erect Views
x		49400	78606P	4	x		x		Nuclear Scan of Brain; Complete, With Vascular Flow
x		49461	76100P	7	x		x		XRAY Exam of Body Section; Other Than Kidney
x		49524	78600P	4	x		x		Nuclear Scan of Brain; Limited, Static
x		49551	78305P	7	x		x		Nuclear Scan of Bones; Multiple Areas
x		50567	82640- *	7	x		x		CHEM-TOX: Digitoxin (Digitalis); Blood, RIA
x		"	82641-	4	x		x		CHEM-TOX: Digitoxin (Digitalis); Urine
x		"	82643-	4	x		x		CHEM-TOX: Digoxin, RIA

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* See note preceding page.

x	x	50704	85580-	7	x	x	x	x	HEMAT: Blood Cell Exam; Platelet Count
x	x	50706	84132-	4	x	x	x	x	CHEM-TOX: Potassium; Blood
x		"	84133-	4	x	x	x		CHEM-TOX: Potassium; Urine
x	x	"	84140-	3	x	x	x	x	CHEM-TOX: Potassium
	x	50747	84450-	7	x	x		x	CHEM-TOX: Transaminase (SGOT), Blood; Timed KUV Method
	x	50757	86410-	3	x	x		x	Laboratory Services, Analysis
	x	"	86592-	4	x	x		x	IMMUN: Syphilis Tests, Qualitative VDRL,RPR,DRT
x		50771	83465-	3	x		x		Laboratory Services, Analysis
x		50774	83450-	3	x	x	x		CHEM-TOX: Thyroxine (T4)
x	x	"	84441-	4	x	x	x	x	CHEM-TOX: Thyroxine (T-4), Method to be Specified
x		50730	84478-	4	x		x		CHEM-TOX: Triglycerides, Blood
	x	50822	84330-	3	x	x		x	CHEM-TOX: Sugar (Glucose); Blood,quantitative
	x	"	82950-	4	x	x			CHEM-TOX: Glucose; Post Glucose Dose
x	x	50834	81000-	7	x	x	x	x	URIN: Routine Urinalysis; With Microscopy
x	x	"	81002-	7	x	x	x	x	URIN: Routine Urinalysis; Without Microscopy

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* Six CPT codes incorporated in the Medicare fee-screen computation but not included in the Medicaid cross-reference list are omitted. Two CPT codes priced by relative value units (status 9) under Medicaid but incorporated in the Medicare fee screens also omitted. These eight CPT codes will be excluded from computation of Medicaid screens for 5-0623. See attached Notes.

PROGRAM SOURCE LIST -CARE ("B")	-CAID ("A")	PROCEDURE CODE MEDICARE (CRVS)	MEDICAID (CPT)	CPT CODE STATUS	STUDY USE -- PROFILE B	A	PRICE B	A	DESCRIPTION
x	x	58001	80004-	7	x	x	x	x	Automated Clinical Chemistry Tests: 4
x	x	58012	80012-	7	x	x	x	x	Automated Clinical Chemistry Tests: 12
x		58015	80013-	3	x	x	x		Blood/Urine Tests
x		"	80016-	4	x	x	x		Automated Clinical Chemistry Tests: 13 to 16
x		"	80018-	4	x	x	x		Automated Clinical Chemistry Tests: 17 to 18
x	x	"	80019-	4	x	x	x	x	Automated Clinical Chemistry Tests: 19 or More
x		58905	88302-	4	x	x	x	x	Surgical Pathology, Gross & Micro; Exam for Ident/Record
x		"	88305-	4	x	x	x	x	Surgical Pathology, Gross & Micro; Diag/Large or Mult Spec
x	x	"	88310-	3	x	x	x	x	Exam of Surgical Specimens
x	x	59101	93000	7	x	x	x	x	Electrocardiogram; Routine/12 Leads, With Interp. & Report
x	x	59103	93010	7	x	x	x	x	Electrocardiogram; Interpretation & Report Only

NOTE: Professional components of lab and pathology procedures are excluded. See attached Notes.

PROGRAM SOURCE LIST -CARE ("B")	-CAID ("A")	PROCEDURE CODE MEDICARE (CRVS)	MEDICAID (CPT)	CPT CODE STATUS	STUDY USE -- PROFILE B	A	PRICE B	A	DESCRIPTION
x	x	67405	77405	4	x	x	x	x	Daily Radiat Ther Treatment Mgmt; Intermediate
x		67550	77550	0	x		x		Supervoltage Per-Treatment Allowance
x		67620	77460	4	x		x		Daily Superfic. Extern. Radiat. Trtmt, Aux. Shielding

APPENDIX NOTES

There were various exclusions, deletions, omissions, and problems concerning "candidate" codes considered for inclusion in the preceding list. The following discussion provides the rationale for exclusions and some details on problems associated with selected codes.

The intent was to derive a list of high-volume codes, plus others needed for computation of fee screens in a manner consistent with reported practices in Arkansas. We believe the list presented, with uses as noted, constitutes the best set of codes which can be designated for the present study. Reviewers are invited to suggest appropriate changes after considering the following comments.

I. EXCLUSIONS FOR ANALYTICAL REASONS

A. Exclusions from Fee-screen Computations

1. CPT codes cross-referenced to a given CRVS but listed as paid by individual consideration (manual pricing) in the Medicare physicians' cross-reference manual. Such CPT codes are omitted from the data aggregated for computation of Medicare fee screens.

2. CPT codes not cross-referenced (CRVS zeroed) in the Medicaid cross-reference listing, hence not included in computation of Medicaid's CRVS-coded customaries. Such codes are normally paid on a basis other than the straightforward automated comparisons of lowest-charge alternatives (e.g., base x relative value units, manual pricing, or according to an absolute Medicaid maximum).

3. CPT codes (such as 92002) which are

   (a) not reported Medicaid high-volume codes and

   (b) cross-referenced to a specific CRVS code in the Medicaid cross-reference listing, but

   (c) not cross-referenced in the Medicare physicians manual or the Blue Shield cross-reference list, thus not included in computation of Medicare for screens; providing

   (d) they are not identifiable Medicaid "addendum" codes.

   Such codes often had Medicaid maximum charge limits markedly discrepant from other codes related to the same CRVS, hence qualify as "outliers" whose inclusion would tend to distort the computed fee screens. They will be excluded from Medicaid screens.

B. Exclusions from Pricing[1]

1. Codes paid by manual pricing in either Medicare or Medicaid. Not amenable to automated pricing in the study.

2. Medicaid codes priced by the method of "base x relative value units," because such codes are not cross-referenced in the Medicaid listing and involve individual determination of what base and which (Medicare or Medicaid) relative value units should be utilized. (This group includes one CPT code whose payment status appears to have been erroneously recorded in the Medicaid reference listing.)

3. Codes with extremely high or low unit prices. On the upper end were four coronary-bypass procedures, with Blue Shield prevailing charges in the range $2,025-3,500 per service, and reported frequencies in the range 13-49. On a payout basis, these reached as much as an estimated $147,000, but were nonetheless excluded as atypical.

   On the lower end were a large number (25 CPT, 2 CRVS) of "professional component" laboratory/pathology codes, for which the Medicaid maximum charge or Blue Shield prevailing was less than $5. Owing to very high frequencies, such codes exceeded $30,000 per year even when the value was as low as $2. From an analytical standpoint, these codes constitute "noise" in the analysis, and are therefore excluded.

4. Lowest charge level codes.

II. EXCLUSIONS FOR PRACTICAL INFEASIBILITY

A. Three CPT codes for which no matching CRVS code was found and two CRVS codes for which no matching CPT codes were found.

B. Any CPT codes unresolvably cross-referenced to more than one CRVS, usually in different cross-reference sources, and CRVS codes whose constituent CPT "load" therefore could not be determined (27 CPT codes and 12 CRVS codes).

The prime example of this situation, and perhaps the most important resulting loss of coverage, are several codes for psychotherapy. The conflicting cross-references are indicated in Exhibit 3, following this appendix. As indicated there, the exact content and appropriate CRVS cross-reference for CPT codes 90843 and 90844 are inconsistent, hence it is not possible to determine what actual procedures are reported with these codes by various Arkansas providers.

---

[1] In addition to those excluded as not high-volume codes.

Various items of information suggest that codes 90843 and 90844 supercede codes 90803 and 90804 (which became non-payable on July 1, 1979) in Medicaid. In that case, they would indicate office psychotherapy for Medicaid providers, who continue use of 90891 and 90892 for hospital psychotherapy according to the Medicaid payment status indication for those codes. The contrasting Medicare specification of (addendum) codes 90838/90839 for office psychotherapy and 90843/90844 for hospital psychotherapy makes it impossible to identify the actual procedures designated within the scope of this study. To do so would require special inquiry among Arkansas providers to determine how they use these conflicting codes.

C. Codes acquiring "candidate" status only as a result of cross-reference to high-volume codes which were later deleted for other reasons. Two such codes were eliminated because the eligible codes to which they referred were deleted.

III. COMMENTS ON SPECIFIC CODES

A. CRVS 2-0171. The long list of cross-referenced CPT codes shown in Exhibit 2 constitutes all codes, except one for which cross-reference sources conflicted, matched to this single CRVS code. In the list, we have departed from strict numeric ordering of the CPT codes to indicate a break in the listed prices indicated by Medicaid maximum charges. Those CPT codes above the divider range between $25 and $60, with seven of the series at $45. Those below the divider range between $100 and $250, with seven at $100. Despite the sharp price differential, our sources indicate that the Medicare fee screens include data from all those CPT codes matched to 2-0171.

Although none of the several CPT biopsy codes was eligible according to the stipulated high-volume criteria, we will price 11100 and 21550 as the representatives most likely to have high frequencies, where probable frequency is judged on the basis of body area covered by the specific CPT codes.

B. CRVS 2-2442. This code is included, despite its failure to meet the minimum 600 frequency criterion, because the payout level is high and the reported frequency (536) was not far short of the criterion. Moreover, the three associated CPT codes are the only available representatives of heart care (other than ECG) with sufficient volume to permit study.

The three CPT codes are treated differently by Medicare, which (a) groups 93547 and 93549 under CRVS 1-2442 (medical) and 93548 under 2-2442 (surgical) in the Physicians' Cross-reference Manual, but (b) lists 93549 as the sole constituent for computation of 1-2442 and 93547 plus 93548 as the constituents for 2-2442 in the Blue Shield fee-screen listing.

Despite this confusion, we grouped all three under 2-2442, in keeping with the Medicaid practice (which has no prevailing charge for 1-2442), because (a) they have similar Medicaid charge limits, (b) they once (October 1978) had equal Blue Shield prevailing charges, (c) the CPT4 manual explicitly links 93547 and 93449 as intimately allied procedures, specifying that 93549 is to be used "when procedure 93547 is combined with right heart catheterization."

C. CRVS 5-0628. As noted in Exhibit 2, several codes cross-referenced to this CRVS in the Medicare physicians' manual were omitted from the main list to save space. Medicare fee screens include codes 85023, 85024, 85025, 85026, 85032, and 85033, which are not official CPT codes and are not included in the Medicaid cross-reference. Codes -23, -24, -25, and -26 are listed in the Medicare physicians' manual as multiples of 85021 (an automated hemogram priced by relative value units under Medicaid). Codes 85032 and 85033 are listed in the physicians' manual as multiples of 85031, a manual hemogram which will be priced by cross-reference to 5-0628 in the study as it is by Arkansas Medicaid.

D. Professional-component codes: Radiology, Pathology, and Laboratory. As explained in the text of the memorandum, special codes are in use to differentiate total and professional-component-only billing for radiology procedures. The CRVS codes involved are numerically distinct in the Medicare database to be used in the study, but extraction and distinction of total and professional-only procedures from the Medicaid database requires use of a procedure modifier. All relevant Medicaid CPT radiology codes will be extracted, the differentiation to occur only in computation of fee screens and pricing.

As indicated in I.B.3, special codes for the professional components of laboratory and pathology procedures were omitted because of their exceptionally low unit prices. With two exceptions (at $5.10 and $8.50, respectively), the 1980 Blue Shield prevailings were much below $5, ranging from $1.60 to $3.40 for high-volume codes for which separate fee screens were listed under Medicare or Medicaid.

EXHIBIT 3

CONFLICTING CODE CROSS-REFERENCES, PSYCHOTHERAPY PROCEDURES

CPT CODE	Medicaid CRVS Cross-Ref and Description (4/80)	Medicare CRVS Cross-Ref and Description (1/80)	CPT4 Status and Description
90803 1/	1-9436: Office Visit/20 min	not listed	not CPT2,-3,or-4
90804 1/	1-9435: Office Visit/50 min	not listed	not CPT2,-3,or -4
90838	not listed	1-9436: Office Psychotherapy, 25 minutes	not CPT2,-3,or -4
90839	zeroed: Psychologist Evaluation	1-9435: Office Psychotherapy, 45/50 minutes	not CPT2,-3,or -4
90843	1-9436: Individual Psychotherapy	1-9439: Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, ... hospital, 25 minutes [Note: "hospital" specified.]	New CPT4 addition: Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, --- approximately 20 to 30 minutes. [Note: "hospital" not specified.]
90844	1-9435: Individual Psychotherapy	1-9438: same as 90843, but 45-50 minutes ["hospital" specified]	same as 90843, but 45 or 50 minutes. ["hospital" not specified.]
90891 1/	1-9439: Hospital Visit/ 20 minutes	not listed	not CPT2,-3,or -4
90892 1/	1-9438: Hospital Visit/ 50 minutes	not listed	not CPT2,-3,or -4

1/ In CPT, 4th Edition, all psychiatric codes and only psychiatric codes have initial "908" digits.

APPENDIX III

Localities

FIVE AREA CODE LIST

Area	County Name	County Number
1	Pulaski	60 and 76
	Sebastian	65
2	Craighead	16
	Garland	26
	Jefferson	35
	Miller	46
	Union	70
	Washington	72
3	Crittenden	18
	Mississippi	47
	Ouachita	52
	Phillips	54
	Pope	58
	Saline	62
4	Arkansas	1
	Ashley	2
	Baxter	3
	Benton	4
	Boone	5
	Chicot	9
	Clark	10
	Columbia	14
	Faulkner	23
	Greene	28
	Hot Spring	30
	Independence	32
	Jackson	34
	St. Francis	68
	White	73
5	Bradley	6
	Calhoun	7
	Carroll	8
	Clay	11
	Cleburne	12
	Cleveland	13
	Conway	15
5	Crawford	17
	Cross	19
	Dallas	20
	Desha	21
	Drew	22
	Franklin	24
	Fulton	25
	Grant	27
	Hempstead	29
	Howard	31
	Izard	33
	Johnson	36
	Lafayette	37
	Lawrence	38
	Lee	39
	Lincoln	40
	Little River	41
	Logan	42
	Lonoke	43
	Madison	44
	Marion	45
	Monroe	48
	Montgomery	49
	Nevada	50
	Newton	51
	Perry	53
	Pike	55
	Poinsett	56
	Polk	57
	Prairie	59
	Randolph	61
	Scott	63
	Searcy	64
	Sevier	66
	Sharp	67
	Stone	69
	Van Buren	71
	Woodruff	74
	Yell	75

APPENDIX IV

System Design

- EXTRACT AND PROFILE BUILD
- PREPARE EXTRACTS
- EXTRACT RECORD FORMAT
- PRICE AND TABULATE

EXHIBIT 4

EXTRACT AND PROFILE BUILD

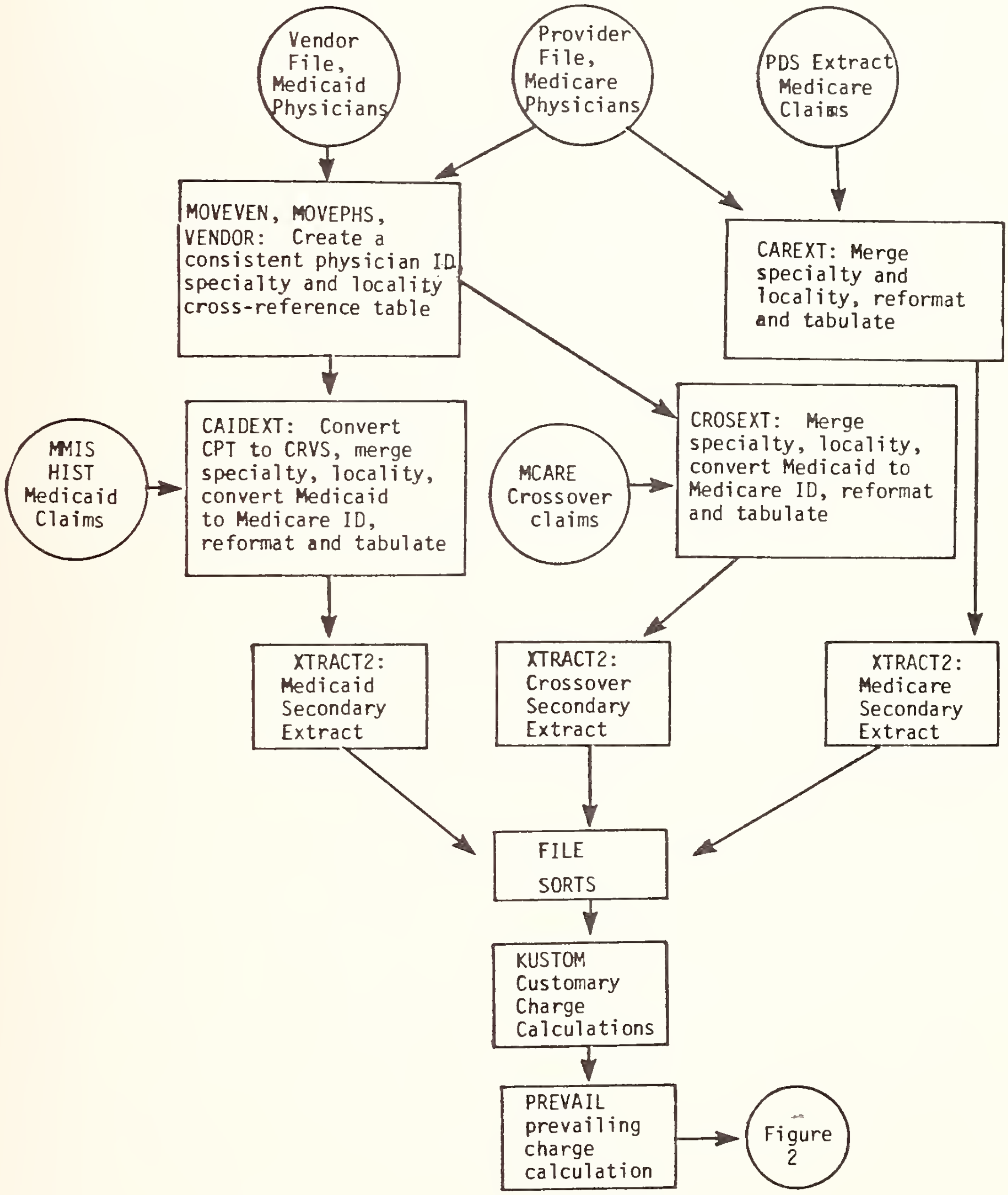

Vendor File, Medicaid Physicians
Provider File, Medicare Physicians
PDS Extract Medicare Claims
MOVEVEN, MOVEPHS, VENDOR: Create a consistent physician ID, specialty and locality cross-reference table
CAREXT: Merge specialty and locality, reformat and tabulate
MMIS HIST Medicaid Claims
CAIDEXT: Convert CPT to CRVS, merge specialty, locality, convert Medicaid to Medicare ID, reformat and tabulate
MCARE Crossover claims
CROSEXT: Merge specialty, locality, convert Medicaid to Medicare ID, reformat and tabulate
XTRACT2: Medicaid Secondary Extract
XTRACT2: Crossover Secondary Extract
XTRACT2: Medicare Secondary Extract
FILE SORTS
KUSTOM Customary Charge Calculations
PREVAIL prevailing charge calculation
Figure 2

EXHIBIT 5

PREPARE EXTRACTS

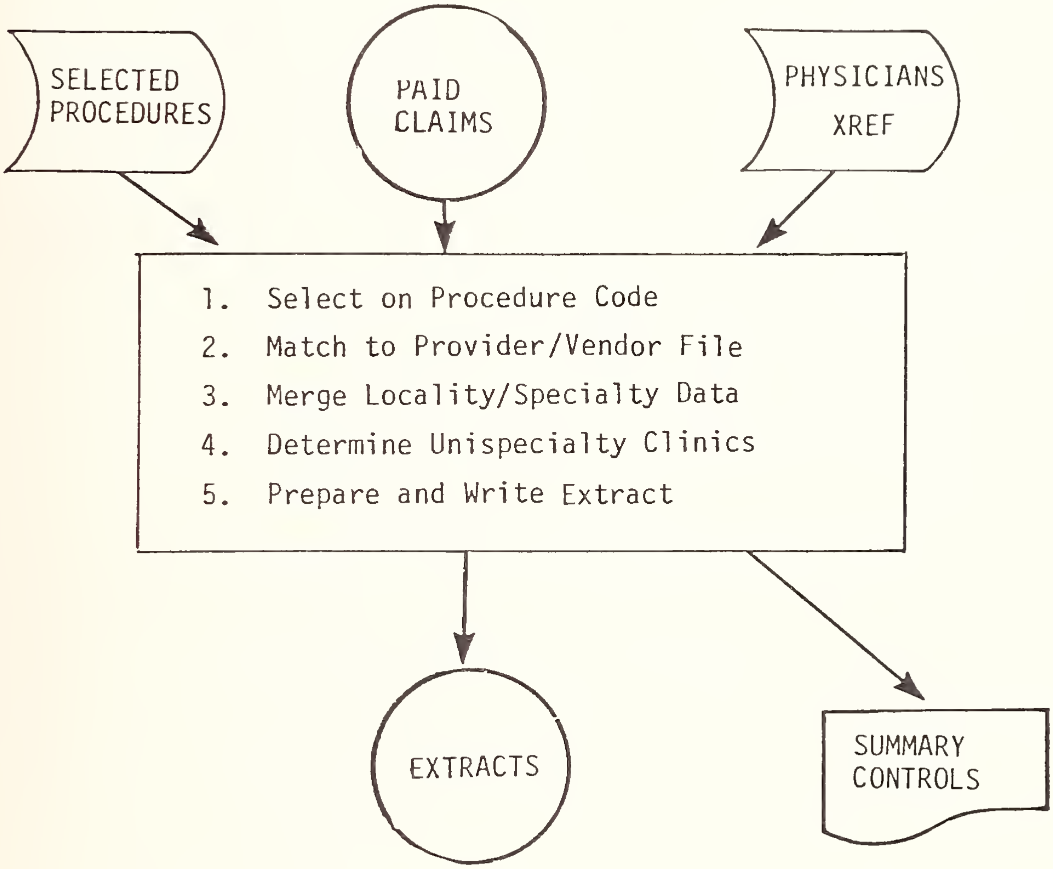

SELECTED PROCEDURES
PAID CLAIMS
PHYSICIANS XREF
1. Select on Procedure Code
2. Match to Provider/Vendor File
3. Merge Locality/Specialty Data
4. Determine Unispecialty Clinics
5. Prepare and Write Extract
EXTRACTS
SUMMARY CONTROLS

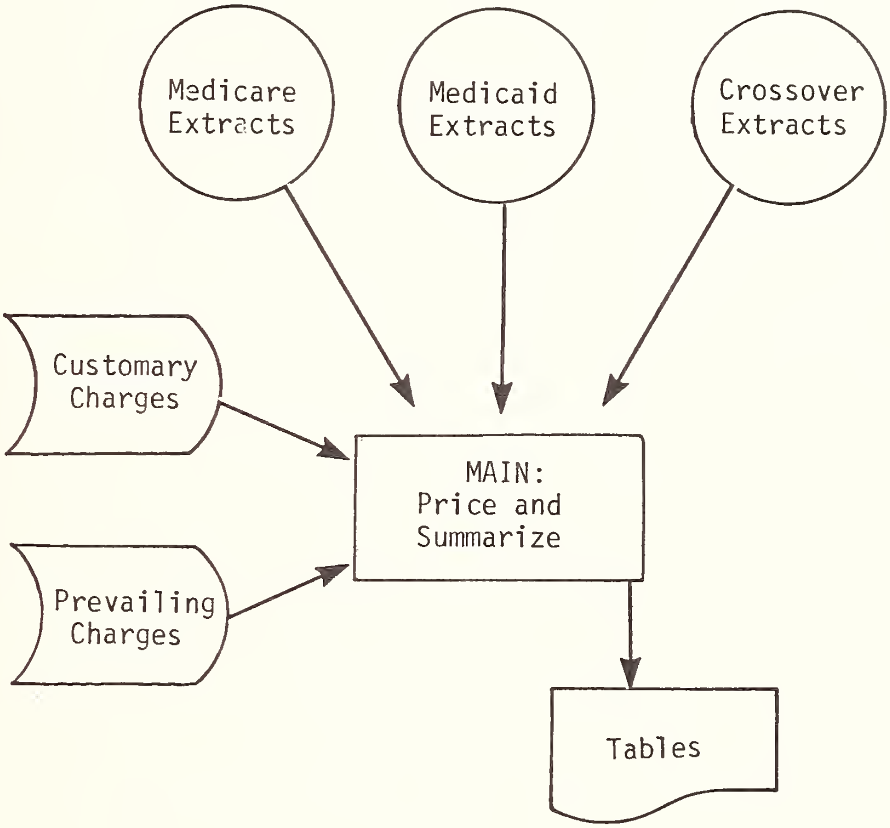
EXHIBIT 6

EXTRACT RECORD FORMAT

	Field	Characters	
	Physician ID	5	
	Clinic	4	
Procedure Code	TOS	1	
	CRVS	4	
	Unit Charge	6	(2 decimal places)
	Allowed charge	6	(2 decimal places)
	Specialty clinic code	1	(0 = no, 1 = yes)
	Number of services	2	
	Service year	1	(1 = 1977)
	Service Quarter	1	(1 = January-March)
	Claim quarter	1	(1 = January-March)
	Fee screen year	1	(1 - 1977)
	Assignment	1	(1 = yes, 0 = no)
	Locality	1	(1-5, 9 = none)
	Specialty	1	(1-3, 4 and 9 = none)
	Medicaid number	5	(Medicaid claims only)

EXHIBIT 7

PRICE AND TABULATE



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